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DETROIT MEDICAL JOURNAL

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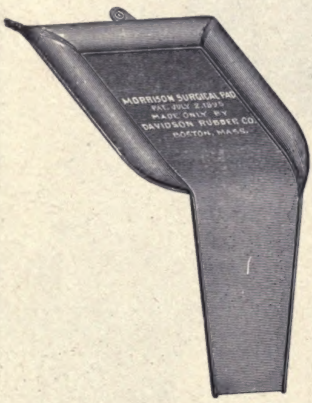

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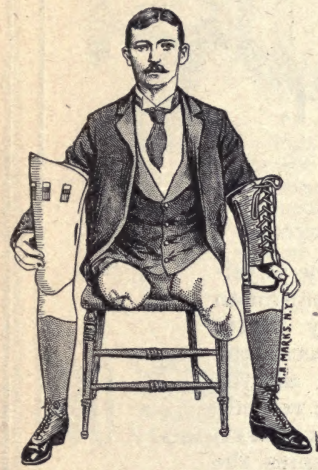

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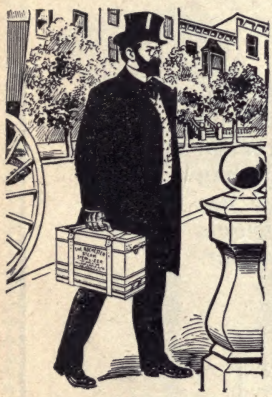

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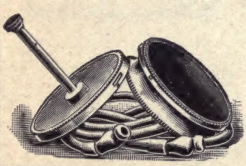

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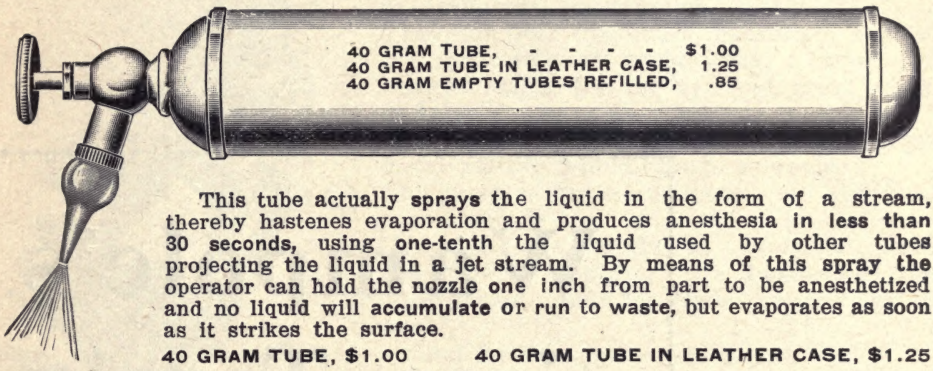

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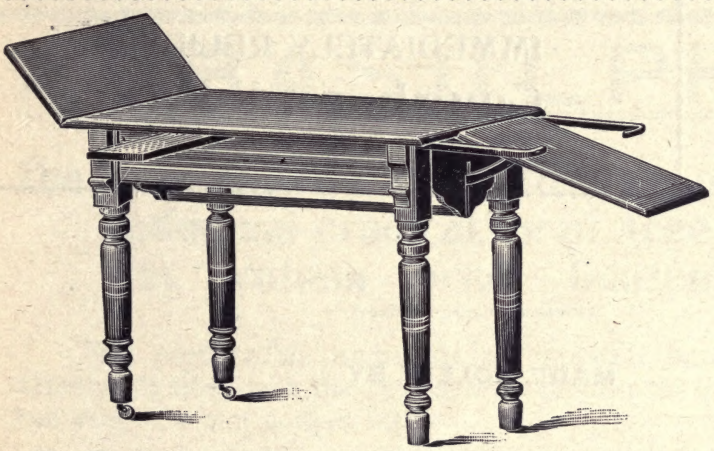

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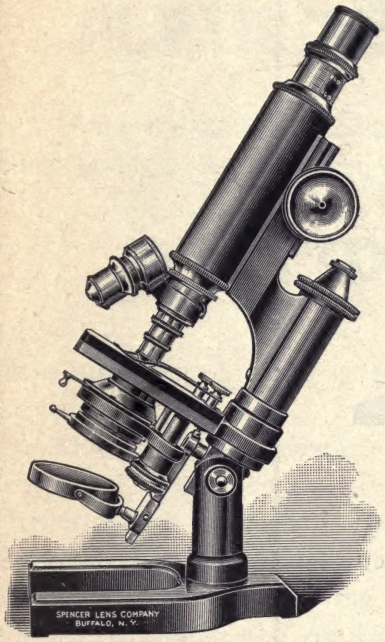

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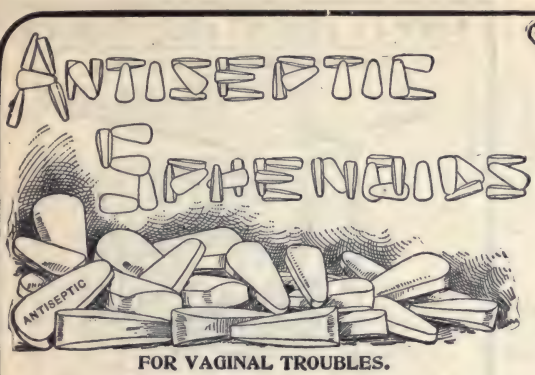

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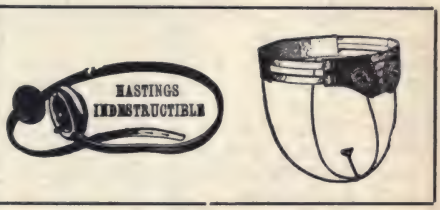

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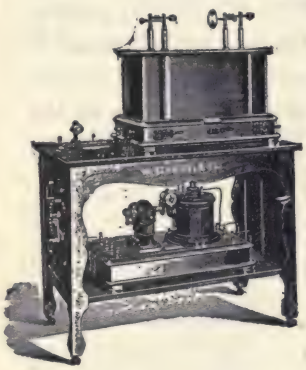

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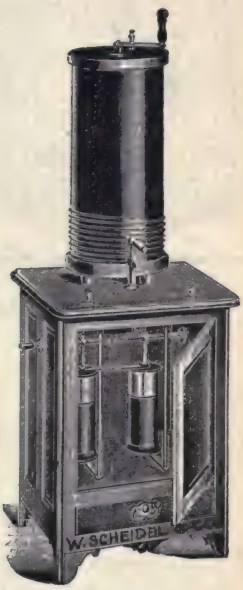

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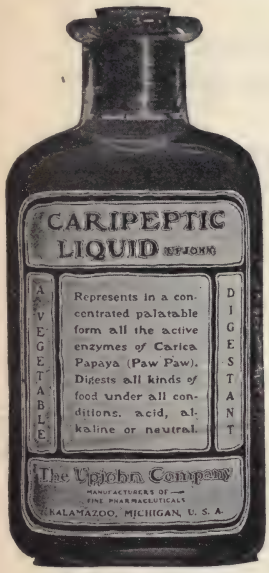
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THE DETROIT MEDICAL JOURNAL.

VOL. IV. FEBRUARY, 1905. No. 11.

THE NEED FOR ACCURATE REGISTRATION OF BIRTHS IN MICHIGAN.

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Following are some of the reasons why it is desirable that a law shall be enacted providing for the prompt and accurate registration of all births that occur in the State:

1. Because the State of Michigan has undertaken to register births occurring in the State for nearly forty years. What the State undertakes to do should be thoroughly done, if reasonably possible to perform. Relying upon the existence of a general law for the return of births, every citizen of the State has a right to expect that the births of his children, or his own birth, if born in Michigan since the law went into effect, are properly placed upon record. If it is found that a very large percentage of births occurring in the State fail to be recorded, the causes of the inefficiency of the present law should be inquired into, and the condition should be promptly remedied.

2. Because failure to register births may cause loss to citizens of the State in after years, such records being necessary as evidence to establish claims to inheritances, to prove descent, to use in pension cases, to establish ages of children or minors for various legal purposes, as, for example, termination of guardianship, school age, factory age, voting age, marriageable age. Evidence in regard to age is not infrequently demanded in cases of "statutory rape," and miscarriage of justice may result from inability to obtain legal proof of the age of the individual.

3. Because the rigid requirement of certificates of births tends to place the lives of infants under safer control. Where physicians or midwives must certify to each birth as it occurs and immediately, or within the shortest reasonable interval, file a certificate with the authorities, we certainly have the first step in the way of prevention of such atrocious cases of wholesale child murder as occurred not long ago in Philadelphia, and may be expected to occur from time to time, or all the time, in all great cities unless the State in some way extends the aegis of her protection over these helpless infants.

4. Because the number of births is a necessary basis for the computation of infant mortality. This is defined as ratio of deaths per 1,000 births, not per 1,000 population under one year of age, and in order to have fully reliable data for comparison with other states and countries in regard to the prevalence of diseases during the first year of life, it is necessary that an accurate registration of births as well as of deaths be had. No more important direction can be given to sanitary effort at the present time than to attempt to prevent some part of the vast mortality of infants, which forms one of the largest

Detroit, Mich., February 15, 1905.

factors of the general death rate. The exact amount of this cannot be definitely stated until we shall have accurate registration of all children born.

5. Because the registration of births supplies the necessary knowledge concerning the movement of population of the State—knowledge which nearly all civilized countries deem essential to the national welfare. In the United States, it happens that legislative action for the purpose of securing such data can only be taken by the individual states, yet, so far as possible, the Federal Government, through the Bureau of the Census, has endeavored to co-operate with them, and Congress, by joint resolution of February 11, 1903, has explicitly urged the necessity of the passing of proper laws for the accurate registration of both births and deaths. In laboring for the proper registration of births in Michigan, therefore, we are aiding in the general movement for accurate registration of vital statistics throughout the country, and are helping to remove the reproach that now rests upon the United States as a nation in this respect.

WHAT IS THE PRESENT SYSTEM AND WHY IS IT DEFECTIVE?

The present law was passed in 1867 and was slightly amended, but not improved in accuracy, in 1869. It provides for the annual enumeration, not *registration*, of births by supervisors or assessors at the time of taking the assessment in the spring of each year. The period of enumeration is from April 10th to May 30th and the returns are to be made to the county clerks by June first of each year.

The county clerks copy the returns in the county records and make copies of said records which are forwarded to the Secretary of State on or before September first. In Detroit special enumerators are appointed by the common council to collect births.

Until 1897 the same system was employed for deaths as well as for births, and the results were fully as bad for that class of statistics as for births at the present time. The reason for this lies in the fact, which has been thoroughly understood by practical statisticians for many years, that vital events cannot be accurately recorded unless *registered* immediately or very soon after their occurrence. If the supervisors did in fact call upon all of the families in their districts each year, during the months of April and May, they would not be able to obtain records of all the births and deaths that occurred during the preceding calendar year. But some of them make a very perfunctory enumeration, and as the returns do not reach the State Department under the law until eight months after the end of the year or nineteen months after the occurence of the births in the first month of the year, it is practically impossible to remedy omissions or to secure missing data.

At the present time probably only about two-thirds of the births that actually occur in the State are recorded, and many of the records made are incorrect. This was formerly true in regard to the deaths also, but the passage of the law in 1897 requiring the immediate registration of deaths, with certificates of deaths and burial permits, and the prompt monthly return to the central registration office has entirely changed this condition, and the Michigan statistics of deaths are now accepted as satisfactory.

LOCAL REGISTRATION OF BIRTHS.

The defects of the State system of collecting births are so well known that it is not surprising that some progressive health departments in Michigan cities have attempted to enforce more thorough registration under local ordinances, but

the results have not been, on the whole, very satisfactory. In Detroit, for example, I may quote from a circular letter issued to the physicians by Dr. Guy L. Kiefer, Health Officer, under date of August 1, 1901:

"Having been in the office a little over a month, I find it necessary to talk some matters over with the profession and I trust you will give this letter some consideration. * * * *

"In regard to births I have been asked: 'Do you want us to report them?' Most certainly I do, but as there is no way of compelling a physician to do so, I most certainly request and beseech the profession to aid me in this work. The Board of Health record is the only OFFICIAL record of births and it is important that it should be complete. Only the other day a person called here to get a certified copy of a birth—the parents of the child had gone to Germany—because it was necessary for them to have it to place on file in Germany. To tell the whole of the story, I must make a confession and that is that I happen to have been the attending physician who had not reported that birth. I was shown most effectually how necessary these reports are, and I now ask those of you who have not reported births to reform and do so."

A letter to me from Dr. Kiefer under date of March 7, 1903, when the subject of an improvement in the registration law for births was under discussion in the Michigan legislature, shows that the condition had not improved, and I presume that results are not materially better at the present time:

"In answer to your letter of March 3rd, I will take up the questions in the order asked and endeavor to answer them. 1. We are not obtaining any better results in the registration of births in Detroit than formerly. Probably about one-third are reported. 2. Neither physicians nor midwives, generally, report births. If there is any preference between them, I should say that midwives comply with the law more thoroughly than do physicians. 3. We have as yet no ordinance requiring the registration of births. 4. The only solution of the problem, in my opinion, is the establishment and *enforcement* of a State law requiring the registration of all births. * * * * A law without provision for such punishment, as it now exists, is, of course, a dead letter."

Dr. Barnett, of Ishpeming, collects births under local regulations, but finds that one physician refuses to make reports. In the monthly reports on vital statistics issued by Dr. A. H. Coté, Health Officer of Port Huron, he says: "For want of a State law for the immediate registration of births, we fail to get a report of a large number." Other examples might be given, but it is hardly necessary to insure conviction as to the absolute truth of the proposition laid down by Dr. Kiefer that "the only solution of the problem is the establishment and *enforcement* of a State law requiring the registration of all births." This is absolutely true, and it should also be remembered that records made under local ordinances, even if they were fairly complete, form no part of the State system of registration, and are not returned to the State Department and preserved as the official records of the State.

HOW CAN BIRTHS BE ACCURATELY REGISTERED?

We may compare the necessary provisions for the registration of births with those established for the registration of deaths by the U. S. Census Bureau and American Public Health Association, with which requirements the laws of all States having effective registration of deaths comply, including those of Michigan.

There is great similarity between the essential provisions of a law for the registration of deaths and what we may suppose to be necessary for the registration of births. It would seem that at least all of the requirements for deaths must be included, as far as the subjects will permit, and thus all of the features of our

NECESSARY PROVISIONS IN LAWS FOR THE ACCURATE REGISTRATION OF—

A—DEATHS:

1. Deaths must be registered immediately after their occurrence.
2. Certificates of death should be required.
3. Burial or removal permits are essential to the enforcement of the law.
4. Efficient local registrars are necessary.
5. The responsibility for reporting deaths to the local registrar should be fixed.
6. The central registration office should have full control of the local machinery.
7. The transmission and preservation of records should be provided for.
8. Penalties should be provided.

B—BIRTHS:

1. Births must be registered immediately after their occurrence.
2. Certificates of birth should be required.
3. (?)
4. Efficient local registrars are necessary.
5 The responsibility for reporting births to the local registrar should be fixed.
6. The central registration office should have full control of the local machinery.
7. The transmission and preservation of records should be provided for.
8. Penalties should be provided.

present successful law for the registration of deaths, except the third item relating to burial permits, may be taken as a basis for framing a satisfactory law for the registration of births. But this item is an absolutely essential provision of the law for deaths, and the question arises as to whether any law for births can be constructed along these lines which will give equally satisfactory results in the absence of this or any corresponding requirement.

It should be frankly stated that this doubt is exceedingly well justified when we come to actual conditions. Laws for the registration of deaths have been enforced, in some parts of the country for many years, with a considerable degree of thoroughness. Their effective administration depends upon the fact that dead human bodies must be disposed of in some way, and the law, acting through the local registrar, forbids the undertaker or other person acting as such to inter or remove a body until a permit has been issued after the registration of the certificate of death. With births, on the other hand, should the record fail to be made, there may be no circumstance to call the omission to the attention of the authorities. It is much more difficult to secure a complete registration of births than of deaths. Not a single State in the Union and no city of any considerable size has such registration, and it will be to the great credit of the people of Michigan if the way can be pointed out in which this can be done. For this end, however, a full knowledge of the inherent difficulties of the subject and of the obstacles which have interfered with the operation of various systems devised for the registration of births is indispensable.

In many respects the present machinery now in successful operation for the registration of deaths could be adapted to the registration of births. We have the local registrars making monthly returns of deaths from every city, village and township in the State. They could register and return births as well as deaths. If the interval of three days proposed for the registry of a birth should be thought too short, especially for rural districts, it could be made a little longer (ten days?). The responsibility for filing certificates of birth should rest upon the attending physician or midwife, just as that for filing certificates of death rests upon the undertaker. Of course, suitable provision should be made for cases not at-

tended by physicians or midwives. Compensation for returns is a debatable question. A fee of twenty-five cents would remove some friction. It would not cause *all* physicians to make reports and the ultimate reliance of the law must be upon the police power of the State to compel such returns, with or without the payment of a nominal fee. If one physician should refuse to register a birth because the law would not pay him twenty-five cents, another might refuse to do so for twenty-five cents, and the idea might perhaps gain credence that it was quite optional to register the birth and take the fee or fail to do so and lose the fee. Effective registration cannot be conducted on this basis, but all alike must, under all circumstances, register all births occurring in their practices, and failure to do so should necessarily incur prosecution and payment of the penalty provided by law.

This leads us to the suggestion of a substitute for clause (3) applicable to births, and affording a check on their accurate registration comparable to that exercised over deaths by the requirement of the burial permit. The law should provide a system of detecting omissions in the returns of births, and provide for the systematic prosecution of physicians and midwives who violate the law. Does this seem harsh? An undertaker who fails to obtain a burial or removal permit before the body is interred or removed from the district in which deaths occurs is liable to fine, and there need be no sympathy wasted in such a case. Shall a physician or midwife who forgets, neglects or otherwise fails to register a birth as the law requires be prosecuted for such neglect? As to the midwife, certainly! But the physician may be of excellent standing in his community and of high rank in his profession; he may have conscientious scruples against reporting his business to the public authorities or against making any sort of a report without adequate compensation. He may have merely "forgotten" or "mislaid" the report. There may be a multiplicity of reasons why it will not seem expedient to prosecute some particular case. Nevertheless, if the law is not executed uniformly and thoroughly for all alike it becomes an offense to all who love justice, and if one man can defy its provisions, then there is no reason why another should not have the same privilege.

Until public sentiment shall fully appreciate the importance of registering all births and be ready to support the uniform and impartial enforcement of a statute making it a penal offense for the responsible parties to fail to make such registration, it is useless to expect complete registration of births or reliable natality statistics.

There are several ways of learning whether all births are being registered or not. One method is by means of a supplementary enumeration, similar to that now made under present law. It would not obtain all births, but it *would* secure some omissions, and the law should provide that investigation and prosecution for neglect to register should follow whenever these are found. Another plan is to examine the returns of deaths for infants under one year of age, or, in time, of infants up to say five years of age. A very large proportion of children born die in infancy. The date of birth and place of birth are given upon the certificate of death. If the latter is in Michigan and the former does not appear, the local registrar at the place of birth may be directed to make inquiry as to who was the attending physician or midwife at the accouchement. This information secured, prosecution and fine should necessarily follow. The fact that the case occurred some time in the past, that it was merely a "trivial" oversight in the physician's opinion, that his intentions were good,

but for various reasons proper performance did not follow,—such circumstances should not serve to excuse neglect. A few examples of real enforcement of the law would act as a deterrent for many possible cases of neglest. But the people and the profession must be prepared to uphold such rigid enforcement, otherwise it is hardly worth while to seriously consider any effort to improve our registration of births.

WHERE DOES THE MEDICAL PROFESSION COME IN?

It is reasonable to inquire at this place what especial benefit, if any, is received by the medical profession from the enactment of such a law. The history of vital statistics in Michigan, as in other States, is largely a history of the efforts of the medical profession to secure adequate legislation and to support the enforcement of proper registration laws, and it may be inquired whether any personal reasons are concerned in the matter. So far from this being the case, it is certain that the enactment of any effective law for the registration of births will place an additional burden upon each physician in active practice, compliance with which will sometimes be annoying, and for which no adequate compensation can be expected. The same has been true with respect to laws for the registration of deaths and sickness, as well as other sanitary laws, all of which place duties upon the profession and do not provide for compensation of more than a nominal character. The fact that the profession will labor with the utmost zeal for the prevention of disease, advocating such measures as the establishment of state hospitals for tuberculosis and the like, when the occurrence of cases of disease and their treatment is what constitutes the source of income of members of the profession in practice, shows the astonishing disinterestedness of what is well considered the most altruistic of occupations. When we find the lawyers attempting to clarify our statutes so that there can be no way of misconstruing them and so inculcating the principles of equity in our schools that litigation will be discouraged and difficulties settled without lawsuits, we shall have a parallel case. We have not quite reached this stage of development yet, but I believe that the medical profession will not hesitate to support a satisfactory law for the registration of births even at the risk of some personal discomfort, and in doing so physicians should not hesitate to emphasize the fact that such advocacy is for the interest of the people, not for the benefit of the profession.

A bill was introduced in the last session of the Michigan legislature by Hon. C. J. Byrns which was drawn according to the recommendations of the authorities of the U. S. Census Bureau and received the indorsement of the committee of the State Medical Socity and of other organizations interested in the improvement of our law. Mr. Byrns has the matter in charge at the present session, and the State Society is also urging the adoption of proper legislation through a special committee consisting of Dr. Henry B. Baker, of Lansing, Dr. A. H. Rockwell, of Kalamazoo, and Dr. George G. Barnett, of Ishpeming. It is quite possible to frame a law that will give results if enforced, and to provide for its enforcement, if the profession and the people of the State will support it. The profession can help to educate the people in this respect, and especially aid in removing difficulties by teaching the small minority of physicians who would oppose any adequate law that the prevailing sentiment of the profession is heartily in favor of the thorough registration of births and that it will uphold all neeessary means for that purpose.

FISTULA IN ANO.*

By J. A. MacMILLAN, M. D.,
Detroit, Mich.

The history of fistula in ano dates back to the time when the upright posture became an established feature of primitive society. The prestige gained for man by the vertical position is not without its disadvantages, and this is nowhere more noticeable than in the ischio-rectal region. The hæmorrhoidal veins are subject to engorgement, which is followed by a reduction in the power of resistance against disease. This is an important etiologic factor in the formation of fistula in ano and must be borne in mind when attempts are made at cure.

Accordingly, pyogenic organisms gaining entrance through lesions in the mucous membrane invade the perirectal tissue and form an abscess. This infection does not tend to subside; more often it extends in directions offering least resistance, so that after the pus has been evacuated large cavities are frequently found which communicate by one or more openings with the bowel as well as externally. In this way the greater number of fistulæ in ano are formed. The ischio-rectal fossa is separated from the bowel by the very thin anal fascia, continued from the lower surface of the levator ani, whereas the anterior, posterior and external walls of the fossa are formed of very firm fasciæ, supported by dense structures. The skin and superficial fascia forming the base of the fossa are not strong. Accordingly, as the pressure of an ischio-rectal abcess increases, the pus is forced to burrow through the bowel and externally.

Tuberculosis of the lungs is so commonly found in patients suffering from these fistulæ that it must be regarded as an etiologic factor. This may be owing to the loss of fat in the ischio-rectal region and the general vital depression which, of course, is especially in evidence in a tissue of low resisting power. In some cases the tubercle bacillus is found in the fistulous discharge.

According to Dr. Alfred Meyer, from 4 to 6 per cent. of phthisical patients have fistula in ano and a much greater percentage of those afflicted with fistula have phthisis. But where careful physical examination is made, unrecognized fistula in ano will be found in many phthisical patients. Many of these complain of no rectal trouble, and attribute their failing health entirely to the pulmonary disease. In a phthisical patient I saw recently, there were two fistulous openings in the skin and one in the anal mucous membrane, and yet she was not aware of any rectal disease.

It is not the purpose of this paper to give a detailed account of the etiology of fistula in ano, but merely to draw attention to some of the more important features, which I shall here summarize:

1. Low power of resistance in anal and ischio-rectal tissue.
2. Pulmonary tuberculosis.
3. Lesions of the ano-rectal mucous membrane, such as hæmorrhoids, fissures and ulcerations, permitting the entrance of pyogenic organisms to the perirectal tissue.
4. Ischio-rectal abcess.
5. Traumatism.

The diagnosis of fistula in ano is not attended with special difficulty. It must be remembered, however, that the local inconvenience and pain are often so slight that the patient is ignorant of the presence of this grave disease, and, further,

*Read before the Wayne County Medical Society, November, 04.

allowance must be made for a certain amount of reticence. When the small, ulcer-like opening exists externally, it will be revealed by careful inspection. However, it sometimes escapes notice when it lies between the anal folds or is hidden by a tag of skin. The anal mucous membrane should be everted and inspected. Over the course of a fistula a well defined induration may be felt, which is still better defined between the index finger in the bowel and the thumb externally.

The tissue adjacent to the rectum, lying between the gluteus maximus and the coccyx posteriorly, the tuber ischii and the sacro-sciatic fascia externally and the perineum anteriorly is normally uniform in thickness, and is very elastic and palpable, strongly in contrast with these dense and unyielding boundaries. Accordingly, in the diagnosis of ischio-rectal abcess or fistula, palpation is very important, for by it inflammatory thickening may be readily detected.

After completing the external examination, there should be a thorough exploration of the gut by the index finger, in order to locate the internal orifice, which in the majority of cases is found posteriorly just above or below the external sphincter. In most cases, the whole interior of the rectum may be subjected to inspection. For this purpose a proctoscope must be used for the upper part, while a speculum is more suited to the region of the sphincters. Beginning at the recto-sigmoidal junction, the proctoscope should be slowly withdrawn and every portion of the bowel brought successively into the field of vision. When the distal end of the instrument comes below the internal sphincter, it provokes powerful and painful contractions and further examination is often rendered impossible.

A speculum, such as the De Vilbiss, or a fenestrated anoscope, is better adapted for inspection of this area. An application of a 10 per cent. cocaine ointment will sometimes facilitate this examination. In some cases of blind internal fistulæ, the opening cannot be found without careful search under a general anæsthetic. To assist in locating the internal opening, milk or permanganate of potash solution may be injected into the external orifice and its appearance internally will indicate the position of the sinus. After one or more openings have been found, the skillful use of probes affords valuable information as to the extent and direction of fistulæ and the presence and location of an internal orifice. Very little force should be used. Probes of various sizes should be at hand and tried patiently, being bent to suit any curve that may be suspected in the fistula. A finger internally will locate the end of the instrument when it approaches or enters the bowel.

In a patient in an advanced stage of tuberculosis, Bright's disease, diabetes, or heart disease, a radical operation is not advisable. This contraindication depends upon the fact that these wounds of operation will not heal when vitality or power of recuperation is greatly reduced. In all other cases a curative operation should be advised. When permission for this cannot be obtained, much can be done for the comfort of the patient by attention to the general health and especially to the regulation of the bowels. Widening of the external opening when it is small and crowded with granulations improves the drainage. Various antiseptic and stimulating solutions are used for injections into fistulæ. Where there is not too much irritability, an application of carbolic acid, followed by injection of alcohol, reduces the discharge and is followed by great relief. As a cleansing solution there is probably nothing better than peroxide of hydrogen and for the pruritus, citrine ointment is a favorite local appli-

cation, especially where there is thickening of the skin.

There are several general rules that apply to all radical operations on fistulæ in ano. It is established by experience extending over more than a century that the entire track of a fistula should be laid completely open. Many operations fail because the incision was not sufficiently extensive to open up the entire canal and its branches. It is equally well established that when a blind external fistula approaches the bowel the probe should be forced through and the complete fistula thus formed treated by free incision. To make this incision, a grooved director is passed along the fistula into the bowel and the end brought out at the anal orifice. All the tissue included by the director is then divided. After this is done, search must be made for any ramifications or pockets that communicate with the main channel and these in turn freely opened. The amount of subsequent scar tissue does not depend upon the extent of the incision, but rather upon the health of the granulations. The wound should be made uniform by cutting away superfluous tissue.

Gant's angular grooved director is useful where there is no external opening. It is passed into the bowel and the grooved portion made to enter the internal orifice of the fistula. The incision is made over the end of the director and the tissues divided as in a complete fistula.

Complete division of both sphincters is rarely necessary and of course is generally followed by incontinence of feces. Even when the external sphincter is destroyed there is often serious inconvenience, and if possible a portion of it should be preserved intact. When the condition demands that some or all of the sphincter fibres be divided, the incision should be at right angles to them and not obliquely.

When the fistulous tract is completely exposed by an incision, the first condition essential to a cure is established. On this, I believe, all surgeons are agreed, but there is some difference of opinion as to the next step of the operation. The weight of authority favors curetting or scarifying the exposed track of the fistula and packing the wound. Before the dressing is applied, the sphincters should be thoroughly dilated and hæmorrhage controlled . The wound should be packed thoroughly and evenly with sterilized gauze, and dry dressing and a T-bandage applied. It is stated in Gant's recent work on rectal surgery that not more than 50 per cent. of operations for the cure of fistula in ano are followed by cure. It is difficult to obtain accurate information on the failures of these operations, but we are all well aware that in a large number of cases there is failure, and failure in cases in which we would expect a successful cure. I do not believe that the fault lies so much in the operative technique as in the after treatment. A faultless operation for fistula in ano, followed by the usual post-operative care, may fail. The kind of after-treatment given laparotomies, amputations and vaginal operations is not sufficient for equal success in fistula in ano. The wound should be dressed at least every twenty-four hours until completely healed. After granulation begins, while the wound is deep, the dressing should be done twice a day.

It is only necessary to say that great care should be taken to maintain surgical cleanliness. However, of equal importance is the gauze packing. At each dressing, from the time of the operation until the healing is complete, the wound should be packed with gauze. But as the object to be attained is not always the same, the method varies somewhat. At the time of the operation, the packing controls the

hæmorrhage, supports the veins and relieves the pain. It should be firm and should exert uniform pressure. After the first day, firm pressure is not needed and it may not only cause considerable pain but also injury, by interfering with the liberal supply of blood to the part, so essential to the process of healing. During the second and the third day, if the sides of the wound be kept separated by the gauze, so that granulation may begin at the bottom, the end of packing is attained. After granulation begins it does not always progress evenly. One portion of the wound may fill up rapidly, while another seems to make no progress. It is important that healing should be uniform. The little area with the indolent granulations may be the bottom of a sinus or may be completely covered over with granulations from the adjacent tissue. To enumerate the purposes of gauze packing, I may give them in the following order:

1. To control hæmorrhage and give relief during the first twenty-four hours—firm pressure.

2. To keep the sides of the wound separated, during the second and the third day—loose packing.

3. To control exuberant granulation and maintain uniform healing until healing is complete, pressure from the gauze is applied as indicated—that is, firm packing where the granulations are exuberant, and very gentle pressure where they are frail.

4. Besides these special purposes served by packing, it has the general function of drainage.

Too much pressure from packing, or pressure applied too long may delay the advent of granulation, produce unhealthy granulation, injure vigorous granulation, prolong the process of healing and create excessive scar-tissue. When the packing is not sufficiently firm, or the gauze not carefully placed in position, there may be considerable hæmorrhage and pain, healing may be irregular and sinuses and infective cavities may be formed. Antiseptic and other applications should be well diluted and mild. Even when there is a considerable discharge, one should withhold heroic measures and resort to frequent dressings and mild cleansing solutions. These granulations partake of the same frailty as the tissue from which they arise. When injured they do not quickly regain their normal condition. I have seen these wounds remain open for months on account of the injury done by harsh applications. As a wash there is nothing better than the saline solution. When an antiseptic seems to be required, 1 to 4,000 perchloride of mercury or 2 per cent. carbolic acid is generally used. Silver nitrate in weak solutions is an excellent application to stimulate indolent granulations. For this purpose, two grains to the ounce is sufficient.

666 Woodward Avenue.

ELEPHANTIASIS—A Mosquito-borne Disease.

By HAL C. WYMAN, M. D.,
Professor of Surgery, Michigan College of Medicine and Surgery, Detroit.

Our great interest in the tropical regions of the earth has drawn the attention of American surgeons to certain diseases which only appear in temperate climates as they are transported there by the individual sufferers.

Many of the tropical ills are vermin borne. The mosquito—as is well known

—carries yellow fever from man to man; flies, ants and other vermin, as well as the mosquito, carry different kinds of the thread-like blood worms—*filariasis hominis*—which give rise to the dreadful filariasis of the lymph channels which causes the cases of elephantiasis, so common in the Malay Archepelago, Fiji, South Sea Islands and East Indies. It is quite common also nearer home, in the West Indies, where it is often called "Barbadoes leg."

The cases which are here depicted occurred in the South Sea Islands. They are typical of scrotal elephantiasis, and each is the result of infection by mosquito bite.

Surgery offers the only remedy for this terrible affliction. In Columbo, I wit-

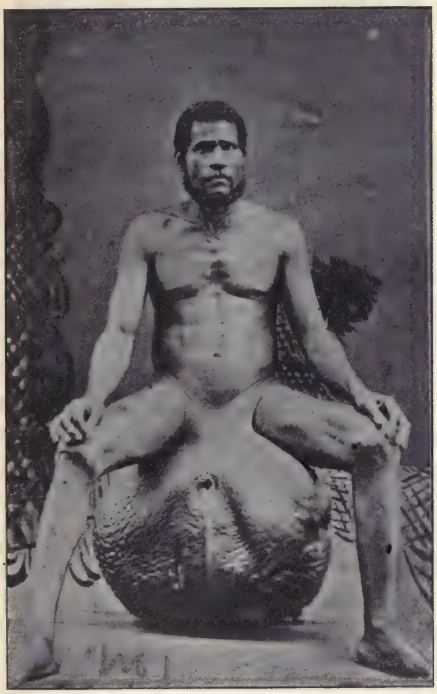

Fig. 1.

nessed several operations for removal of these huge lymph tumors. The arteries are all very much enlarged; the *internal pudic* was on each side nearly as large as the *femoral*. The *superficial perineal* arteries are also greatly enlarged.

In removing the tumor, these vessels were carefully tied and cut between two ligatures; smaller vessels, arteries and veins, may be caught with hemostats as

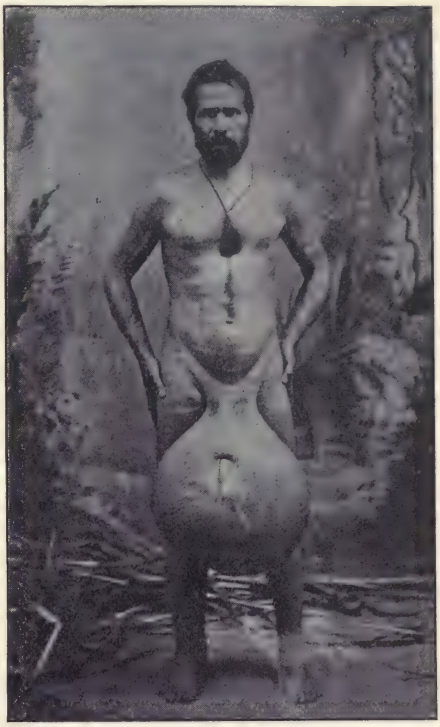

Fig. 2.

soon as divided. Flaps are made to cover all the genital tract as it may be uncovered and exposed during the operation. If care is taken to control hemorrhage, healing commonly takes place uneventfully.

Cut No. 4 shows a case in which the filariasis is limited to the lymphatics of the upper and inner aspect of the thigh and a part of the scrotum. It may be treated by amputation of the affected part,—the skin and superficial lymphatics. Antiseptic precautions are very necessary after the operation to avoid streptococcus infection of the lymph stumps.

When the cases are left to themselves, the skin cracks open and a more or less

copious lymphorrhea results; the general health begins to fail, and the patient commonly succumbs to general tuberculosis.

Ingenuity of local surgery in Ceylon

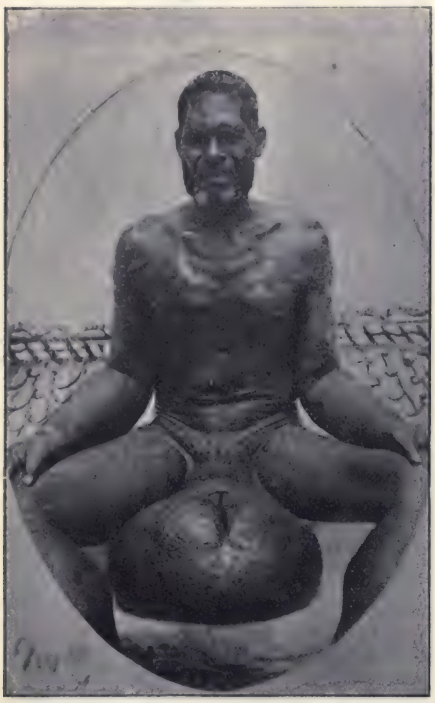

Fig. 3.

and the Malay Peninsula, has been much exercised in the development of apparatus and elastic bandages to act as tourniquets to control hemorrhage during amputation of these huge tumors of thigh and scrotum. My observations lead me to think that the best results are accomplished with free use of the blunt hemostat forceps.

Now that we are about to build the Panama Canal, and thousands of our citizens will visit the Isthmus, it is well for us to have in mind the infectious-

Fig. 4.

parasitic character of not only elephantiasis, but other ills. The mosquito thrusts his beak into the blood of one afflicted with filariasis; on withdrawal, some of the filaria are entangled in the beak, and when another presumably healthy victim is bitten, the filaria are inserted into the wounded tissues.

THE TREATMENT OF SYPHILIS.*

By ROBERT S. WALKER, M. D.,
Toledo, Ohio.

Syphilis may be defined as a specific infectious and chronic disorder, resulting either from inheritance, or from immediate or mediate transference from an infected to an uninfected person. The disease is divided into three stages: the first stage beginning after the lapse of a characteristic incubative period with the ap-

*Read before the Northern Tri-State Medical Association, Toledo, Jan. 10, 1906.

pearance of an initial lesion at the site of infection; the second, indicated after an interval of time by symptoms of systemic derangement, and the third stage when finally there is gumma.

It is not my intention to give you anything new as regards errors in treating syphilis nor shall I suggest any new methods of treatment, but I shall give you my ideas as to how this disease should and should not be treated, with the well-known methods of the general practitioner. Furthermore, I shall take it for granted that the disease has clearly shown manifestations of the second stage and I shall confine myself to a discussion of the treatment of the disease as found in this stage, for it is only in the second stage that the disease can be cured. I shall not discuss the frequent errors made in recognizing the initial sore, nor shall I discuss the cases of the third stage, that is when mercury has ceased to be the proper drug, and the iodides must be resorted to. There is, however, an exception to be made, namely, in cases where the mercury is of more service than are the iodides, and this is indicated in all cases in which the presence of the third stage is made manifest within 3 or 4 years after the initial sore. And now a word as to the disease itself.

Syphilis does not sustain etiological relations with tuberculosis, or any other known disease, and one attack usually makes the subject immune to subsequent infections. It affects individuals according to the amount of poison absorbed at the time of infection, as well as according to the general physical condition of the infected person. It shows several types or forms, which it is impossible to describe separately, so it is well to group them into four classes, as follows:

First: The Benign.

Second: The Benign with a tendency to relapse.

Third: The Severe.

Fourth: The Malignant or Precocious.

The Benign form runs a typical course with complete recovery in about two or two and one-half years. The treatment in these cases is very simple, all that is required is the mercury by the mouth three or four times daily; preferably the protoiodide in one-quarter grain doses. Rarely in these cases is the stomach disturbed, but the patient ought to be seen frequently.

Should the rash be slow in fading, the fourth dose at night will soon affect it. While these cases are easy to handle from a medical standpoint, they are quite hard to manage in some cases, as the patient is liable to get careless, lose all interest in the treatment, and perhaps neglect it entirely. These individuals I always advise a trip to Mt. Clemens or some other resort, according to their means, that they may see a few cases of the severe or the malignant type, and thereby be impressed with the seriousness of the disease, so that on their return they will carry out the treatment faithfully, although ostensibly they go to take a few baths.

The second class, or the Benign with a tendency to relapse, is usually a mild infection found in an individual whose general system is slightly below par and who is addicted somewhat to the excessive use of alcohol and tobacco, with an occupation a little too confining, or it may be found in persons of good physical condition who have absorbed a large amount of the poison. In these cases the rash is slow in fading, while the papular lesion appears early, with moist papular sores about the anus, or on the scrotum or in *both places,* together with recurring sores in the mouth.

In these cases the mercury given by the mouth does not seem to improve the condition, so I give the patient a few doses of the mercury hypodermically, ten to fifteen doses aided by a general tonic

being usually sufficient to get the disease under control; when I return to the mercury given by the mouth, repeating both the hypodermic injection and the tonic, should there be a recurrence of any of the lesions.

The third class, or severe form, consists of cases in which there has been a large amount of poison absorbed by the patient, and where there is more or less leucocytosis with loss of weight before the rash appears. With the appearance of the rash, there are all the symptoms, of an eruptive fever, and especially a gastro-intestinal disturbance, followed very quickly by a papular or a papulo-squamous eruption. In these cases it is utterly useless and perhaps worse, to waste time with mercury given by the mouth, and I resort to injection immediately, but after all lesions have disappeared then I think it is just as well if we return, and I do return to the medication given by the mouth.

The fourth, the malignant or precocious type, as a rule, is found only in the lower classes of people who are surrounded by very poor hygienic conditions. These cases should be treated by injections and the patient will show improvement when their surroundings are changed for the better, but they have an antipathy to decent surroundings, to doctors, and to cleanliness, and as a result, about seventy-five per cent. of these cases do not get well, while seventy-five per cent. of the cases in the other forms do get well, and the other twenty-five per cent. is made up of the careless ones in the first two types, and of the careless and unfortunate ones in the third type. The failure to recognize these four classes and especially the failure to recognize and consequently to take advantage of the peculiarities of the individual cases, is to my mind one of the most common and one of the most serious errors made in the treatment of syphilis. For example, in all cases the kidneys should be carefully watched. In fact a frequent examination should be made throughout the entire treatment, as it is a well known fact that mercury is a kidney irritant. In impaired kidney function the mercury by injection seems to be especially irritating, especially in individuals advanced in years, and it is fortunate that the majority of cases of syphilis are found in the younger folks who suffer less with kidney diseases.

But the main point is that syphilis should not be treated in a routine manner with mercury and the iodides, simply because it is syphilis of the first, second, or third stage, without reference to the amount of infection, or without regard to the complication, or the individuality of the case. I can not too strongly emphasize this feature of the treatment, for in my estimation, the greatest element of success or failure is due to our recognition of the individual conditions or peculiarities. For example, while you know that in the second type mercury should be given in comfortable doses, yet we sometimes find that when the ordinary dose of mercury is given, the patient does not improve as rapidly as we should expect, and does improve greatly when the dose is diminished. This is an individual peculiarity and a failure to recognize it will not lead to successful results. Again is the person debilitated, because of any chronic disease, especially such as tuberculosis, Bright's disease, chronic gastritis, and still more especially is he afflicted with any disease particularly affecting the lymphatics, which are the patient's arms of defence? We must take cognizance of local conditions and if the patient has any of these disorders, the case must be treated differently than is an ordinary case of syphilis, and the failure to do so will often result disastrously to the patient. The treatment must be reg-

ulated according to the attendant conditions.

While in the second stage of all these types of the disease, mercury should be carefully administered, in connection with it iodine should also be given in the last six months of the treatment. In this connection I might say that in the first or second type the physicians often prescribe mercury by the mouth or give the patient a syringe for injection allowing him to treat himself for a long period of time without seeing him. This, in my opinion is a mistake, as the patient should be examined once a week, so that drugs for the purpose of elimination may be given, if necessary, except when the insoluble form of the mercury be given by injection, and especially should he be seen frequently, so that the mercury could be pushed, in the exacerbations of the disease.

I do not think it is a good plan to confine one's self to any one method as to giving the mercury, such as the cycle, the routine inunction, the routine injection, or the routine method of giving the mercury by the mouth, for the simpler the method conducive to the best results the more ideal is the treatment, and I follow the method which best presents the combination of large dosage, easy tolerance, convenient administration absolute control and excellence in clinical results.

I shall now speak more in detail as to when injections, inunctions and mercury by the mouth should be given. The cases which should be chosen for injection are the ones of the second, third and fourth types, in which there is a necessity for the patient to be brought rapidly under the influence of the mercury to check a rapidly destructive lesion, to prevent loss of function or disfigurement, to preserve the lymphatic glands, and in all cases where there is much leucocytosis from any preceding cause. Injections should be given in the third stage of the disease, when paralysis is impending, or there is destruction of brain tissue suspected, in fact it is imperative that injections be administered in all emergency cases where a rapid and profound effect is necessary, unless there is an individual contra-indication, such as a serious kidney disease. There is no doubt that the injection places the drug where we can get the greatest result in the shortest time when we use the mercury in the soluble form, and for this purpose I use Collins' formula which is,

℞ Hydrargyri Bichloridi,
c. p. ..... grs vii
Sodii chloridi ..... grs iv
Aqua q. s., solo
chloritoin ..... grs vii
Alcoholis ..... m xv
Acqua, q. s., ad ..... ʒ iii

This makes a good mixture and is usually painless when injected. The reason for adding the alcohol is that the chlorotone is not readily soluble in cold water. The chlorotone, as you know, is a good local anæsthetic, antiseptic and withal is non-toxic. The alcohol is just enough to hold the chlorotone in solution and not enough to produce pain. Five mms. of the above mixture represent 1-5 gr. of murcury and it can be given in steadily increasing quantities up to as much as 25 mms. but only after the tolerance of the patient is established. Of course, these injections are given under aseptic conditions as regards patient, syringe, needle, and solution, and preferably should be given into the gluteal muscles.

In case the patient can not, for one reason or another, come daily for his injection, I use an insoluble form of mercury, generally the salicylate suspended in alboline, in from ½ to 1 gr. doses every two weeks. This, while not answering the purpose as well as the daily injection of the soluble mercury, is the best substitute that can be had for the daily treatment. It is also well to have in mind that when we use the insoluble form of mercury, we must use a longer needle than is required

for the ordinary injection of the soluble form. While the above mentioned cases are the ones usually chosen for treatment by injection, you will bear in mind what I have said against any routine treatment. The objections to routine injections, are: *First,* the soreness that is occasioned; *second,* the danger imminent from abscesses resulting from non-aseptic injections; *third,* the complication that may arise in cases where the pateient is afflicted with kidney disease; *fourth,* the horror of the needle. The last objection becomes quite important when we consider the traversing of a vein by the needle. While it must be admitted that some veins will be transversed in every injection, yet when the syringe is detached from the needle and there are indications that a large vein has been transversed, it becomes necessary to make a second or even a third puncture. This, it will be readily admitted will be an uncomforable procedure for the pateient. Consequently, I wish again to call your attention to the fact that the simpler the method of treatment the more ideal it becomes, for while it is absolutely necessary to use the injections when the patient must be brought under control quickly and profoundedly, yet after this has been accomplished, it is not necessary to adhere to the routine treatment by injection, but we should return to the simpler method, and give the mercury by the mouth.

The cases chosen for the mercury medication by the mouth are the ones of the benign type. Second, the ones of the benign type with a tendency to relapse, after all gastro-intestinal disturbances have ceased and all skin and mouth lesions have disappeared. Also in some cases of the severe type when all lesions have disappeared and the patient is easily brought under the influence of the mercury. In these cases it is just as important that the patient be seen often, as in the more severe cases, as the administering of an eliminative is very frequently required. It is also a good plan to have the patient wash out the lower bowel once a week to remove any accumulation of unabsorbed mercury which is more or less present when it is given by the mouth.

The chief objections to giving the mercury by the mouth are: First. The length of time it requires to affect the patient; consequently it is contra-indiindicated in the severe forms of the disease. Second. The irritating effect in cases where there already exists some gastro-intestinal disturbance. Third. In cases where great accuracy is required. Fourth. In some cases its debilitating ef fect.

The classes of patients chosen for the inunctions are the ones in the last three types, where the injection is contra-indicative of producing rapid results, and those in which the patient has been brought under the influence with injections and the gastro-intestinal disturbances are still a factor. Inunctions should also be used when it is necessary to give the patient a rest after the medication has been given by mouth and a second attack of gastric trouble has developed. Especially are inunctions to be used in cases of new-born babes who have inherited syphilis. In this class of patients I have used the oleate of mercury, with very good success. Generally for the inunctions I use the officinal preparation, using at each treatment about a dram of *unguentum hydrargum,* which is very satisfactory. But in these cases all that is required is that the patients get mercury, and it does not matter what formula is used. The ointment should be applied in the evening just before retiring and to a different part of the body at each treatment, beginning, perhaps, with the right arm, then treating the left arm, then the chest, then one gluteal region and so on

until the entire body has been annointed. Salt baths should also be given at intervals of about five days. And in this connection, I might say, in my opinion, the baths given at the resorts are good in only so far as they keep the skin in good contion for absorption by inunction, and the being at the resort relieves the mind of the patient from business cares and domestic publicity when inunctions are to be used, but the salt baths taken at home are just as effective.

Although it is the concensus of opinion of the leading European writers on this subject, that treatment by inunction and baths is the best, yet to the general practitioner, this plan is not practical, or so it seems to me. The objections are: First, the extreme uncleanliness; Second, the publicity; Third, the soiling of the bed linen and underclothing; Fourth, the danger of setting up dermatitis; Fifth, the impracticability in cases of hairy individuals; Sixth, the fact that mercury being more or less volatile at body heat is contra-indicated in all cases where there is any disease of the throat or lungs, and also the fact that the patient is required to give the inunctions himself, generally having no attendant because of expense or publicity. Consequently I usually eliminate inunctions from my list of treatment except in inherited cases in children, and in cases where the injections are contra-indicated and it is impossible to control the disease with mercury given by the mouth.

After the patients of the first or second type have been treated according to these methods for eighteen months, and all singns of the disease have long since disappeared, I ask my patient to desist from all treatment for six months, but with orders to report once a month or immediately should there be any re-appearance of the disease. Should there be a recurrence of the disease the paient is again put on the tretment, and it is continued for another period of six months, and at the end of that time, he is again dismissed with the same orders, and should there be no return of the symptoms he winds up the treatment by taking small doses of the mercury and the iodides for six months, when I am justified in feeling that he is cured and tell him so.

In conclusion, in this paper I have called your attention to the four types of this disease usually recognized by the general practitioner and have pointed out the various methods of treatment. While it is known and conceded by all that mercury is the main stay in the second stage, yet I have tried to show you that it makes no difference as to what formula is used, but it does matter greatly as to what method is employed in administering the drug in the different cases, and I have indicated, in a general way, what classes of cases should be chosen for each kind of treatment. But above all, I have tried to make it clear that if we are aiming at success, it is absolutely imperative that we discard all routine methods of treatment and change from one method to another as indicated, or contra-indicated by the individual peculiarities of the disease or of each patient.

29 Bancroft Street West.

An Anaphrodisiac.—

Herein is recommended by Heins as an anaphrodisiac in the following conditions:

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2. Morbid exaggeration of the sexual desire.

3. Operative procedures on the penis, in order to prevent erections, which with most men occur in the morning.

4. Too frequent pollutions.—*Berlin Klin. Wochenschrift*, Nov. 23.

DETROIT MEDICAL JOURNAL

A MONTHLY EPITOME OF
PRACTICE AND THERAPEUTICS

HERBERT M. RICH, M. D., Managing Editor

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Address all communications to 103 and 105 Miami Avenue, Detroit, Michigan, U. S. A.

Vol. 4. DETROIT, MICHIGAN, FEBRUARY, 1905. No. II.

Misapprehensions.

DEFENSE LEAGUE OF THE WAYNE COUNTY MEDICAL SOCIETY

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Editor Detroit Medical Journal:

Under the above caption, the *Medico Legal Bulletin,* published by the Physicians' Defense Co., reprints in its January number the following part of an editorial written by me for your December number entitled "Medical Defence."

"The editor, for example, has paid four annual premiums to such a company and yet defends himself, because with this company a man must carry his policy the number of years allowed for suit under the statute of limitations of his state before he is fully protected by it. What the profession wants is adequate defense during the time that the individual contributes his share to the expense fund, just exactly as life and accident insurance are written. While you are paying you are protected, when you discontinue payments protection ceases."

Upon this extract the Bulletin comments as follows:

"The contract of the Physicians Defense Company is not of this character. The statute of limitations has nothing whatever to do with its operation, excepting in so much as it limits the liability of the company, as it limits the liability of the physician holding the contract. This contract begins to operate the moment it is issued and *covers all acts done* during the time it is in force. A contract issued January 1, 1903, to January 1, 1904, will not cover acts done previous to that time. If suit were filed, however, in 1905 for some act committed between January 1, 1903 and January 1, 1905, the contract would cover such suit, although the physician may not be a contract holder when the suit is filed. Any other arrangement would be in effect ex post facto, and would certainly result disastrously to the company issuing such contracts as well as to the contract holder. For, in the first place, any person, after he knew he was about to be sued, could purchase a contract and need not do so until he was sure of being sued. In the second place, after he had purchased a contract, he would have no certainty as to his protection for the simple reason that the contract would only cover the present time."

If the Bulletin misaprehends my meaning possibly others may, as well, and I take this opportunity to make myself clear. The Michigan law now allows three years after the cause of action arose during which suit for malpractice may be begun. The Defense Company contract and all other Insurance Company contracts cover only acts done while the policy is in force. A contract issued January 1, 1905, will not cover cases attended before that time, hence until January 1, 1908, a man is always liable for cases before he took the contract even though

he carries it for the entire three years. If the statute of limitations allowed 6 years as it used to do instead of three as at present, then one would have to carry one of these insurance policies for six years before he would have absolute protection in case of suit.

On the other hand the company is liable until the statute of limitations protects it for acts done while the policy was in force and might have to defend a suit brought nearly three years after the policy was discontinued. The Defense League, under its plan of organization, can take care of the past and the present just as well as the insurance companies take care of the present and the future.

The Bulletin is quite correct in stating that private corporations could not write a retro-active contract because we would all wait until threatened, before taking out a policy at twenty dollars a year.

On the other hand the Defense League can safely agree to defend a member for his past acts because it thus secures a permanent contributor inasmuch as a man who secures complete protection for five dollars a year can never afford to be without it if he has no protection when he ceases to be a member. If a man waits until threatened before joining the League, he still has all the protection the League and its attorneys can give him but must himself pay the court fees of the League's attorneys should his case go to trial, while if the League succeeds in preventing suit, he has nothing to pay. Hence the only possible contingency not provided against is suit against a member after his death and this additional protection will be arranged for as soon as the League is well organized.

Therefore, contrary to the assertion of the Bulletin, a member of the League has absolute certainty as to protection so long as he remains a member. If he drops his accident or life insurance policy he may be injured or die tomorrow. If he drops his League membership he may be sued the next day.

Therefore, don't dispense with any of these necessities, least of all your League membership. The Defense League offers a new and in my judgment, the best solution of the problem of medical defense.

In order to be an absolute success it requires the support of only a half or two-thirds of the members of the Wayne County Medical Society. It will give as perfect a fighting defense as the private corporations and an annual cash dividend of 300 per cent. to each member in money saved. It establishes a local depository for our money under our own eyes and management, with every member as a stockholder. We, in Wayne County, have paid over five thousand dollars for protection since insurance companies began writing this kind of business, and not one cent has come back in defense of any suit. This means that actual suit is rare. Most threats are blackmail and subside before a stiff show of resistance. The League will be a more powerful implement in disposing of these bluffs at blackmail than any outside corporation and for the rare case which comes to trial will have ample funds for a fighting defense to the highest court.

One very strong point about medical society defense, such as our League offers, is that the organization and plan and funds are ours, hence as soon as sufficent funds accumulate it will be possible to materially widen the scope of the plan and render service to members not limited by a hard and fast contract. An insurance contract on the other hand is iron-clad and not elastic. For example, I wrote the company to whose treasury I had contributed for three years that I had won my case in the Circuit Court on the plea of "Res Adjudicata," a point which the Michigan Supreme Court had

never passed upon, and asked whether in case of appeal, the welfare of the profession and their own interests would not justify their taking the case from this point. In reply I was advised that they could not think of assuming responsibility for any case not covered by contract.

Certainly a contract which leaves a man fighting his own battles after paying three annual premiums has much to be desired and yet nothing better is available until we create it. My company is, I think, the best in the field, but any one of these insurance contracts may fail to protect when needed because they are iron-clad business propositions written designedly to protect the treasury of the corporation rather than the interests of the individual. I would object also to the clause in all these contracts which reads "The Company may cancel at any time the unexpired portion of this contract upon written notice mailed to the holder hereof," etc.

To quote the words of the Bulletin "After he has purchased a contract he would have no certainty as to his protection."

Yours truly,
F. B. TIBBALS.
Secretary-Treasurer Defense League.

It Should Not Pass.

The bill introduced in the Senate by Mr. Doherty to amend the act creating the State Board of Health by which the present secretary will be legislated out of office, should be passed. The present secretary has held his sition year after year and his arbibitrary action has been the subject of much comment and dissatisfaction. It is also well understood that the expenditures of the office have exceeded the value of the services of the board, the board having carte blanche in the conduct of affairs. Such a system is bound to be pernicious. The accounts of every board of the state government should be under the supervision of the board of auditors so far as expenditures are involved. The bill of Senator Doherty provides:

"At the meeting of the legislature in 1905 and every six years after, the governor, with the consent of the senate, shall appoint a suitable and competent person to be the seventh member of the board, which member shall be secretary of the said board and its executive officer."

There can be no valid objection to this measure. It is in the interest of the state government and of the taxpayers of the state and it should be passed.—*Bay City Tribune,* Jan. 30.

We would respectfully like to ask the *Bay City Tribune* and one or two other papers who have printed something like the above editorial, their object in supporting such a disgraceful bill as the measure above referred to. The bill is proposed for the express purpose of ousting from office Dr. H. B. Baker, now Secretary of the State Board of Health. There are two factions—very small ones—who desire Dr. Baker's removal. One faction is composed of physicians who have been taken to task by Dr. Baker for neglect of duty in regard to the public health, as failure to quarantine small-pox cases; the other faction is composed of a small group of petty politicians who have asked to have some henchman appointed to a clerkship in the office of the State Board of Health. Dr. Baker, having an efficient and trained force of clerks, refuses to turn them out for no other reason than that a legislator wishes his sister-in-law to remove to Lansing,—or some similarly bad reason.

The basis of this bill then is spite—nothing more. There has been not a single complaint of Dr. Baker's work from the men competent to judge of its value. The State Board of Health, com-

posed of men of high ability and standing, has not entered any complaint in regard to their Secretary; the State Medical Society, composed of leading practitioners who are intimately associated and acquainted with Dr. Baker's work, has not complained; no one has heard any County Medical Society find fault with Dr. Baker, although the said societies did not fail to promptly attack the Regents of the University when it was thought that the doctor's toes were trod upon. In fact there is absolutely no reason for the introduction of such a bill.

The one argument above is that the expenses of the Board of Health are not passed upon by the State Board of Auditors. Will some one kindly explain why that is a reason for Dr. Baker's dismissal? The legislature provided the original method of book-keeping; no doubt they can change it if they wish.

But to remove Dr. Baker for any such reasons as are given would be a lasting disgrace to the state, and a triumph for bar-room politics. We refuse to believe that the legislature of this state will become a party to any such spite work as this. The removal of Dr. Baker would be a distinct loss to the state. Under his direction the work of the Michigan State Board of Health has acquired international distinction and Dr. Baker's fame as an authority on matters of public health has reflected creditably on the state. Under his consistent and urgent guardianship, the laws concerning the public health in Michigan have been improved, and their enforcement rendered more efficient year by year. To refuse to uphold the executive health officer of the state in his efforts to do his duty is to let down the bars to pestilence and quackery. We believe the spite-mongers will find that the time has passed when the State of Michigan can be managed in that way.

The Registration of Births.

Michigan's present law concerning the registration of births has not been changed for over thirty-five years. In that time, great changes have taken place in the state and plans which were efficient for carrying out the details of public functions then are now found entirely inadequate. Among these is the law above referred to. It is the one glaring defect in a system of vital statistics which is not surpassed by that of any state in this country. And this one failure—to supply such a fundamental item as births—has a depreciating influence on the whole mass of vital statistics which are compiled by the state. Governor Bliss urged that the law be changed. Governor Warner has done the same, his own experience in the office of Secretary of State showing him its necessity.

We are glad to furnish to our readers this month a timely article on this subject by an acknowledged authority. It is a matter in which physicians are decidedly interested and concerning which they have considerable chance to mould public opinion. It is to be hoped that none of our readers will allow an opportunity to escape to help this measure along.

Hon. Frank Wells.

It is with great regret that we chronicle the sudden death from typhoid fever of the Hon. Frank Wells, for many years president of the State Board of Health. Mr. Wells was about seventy years of age; he had long been identified with the best element of the business world of Michigan, having been president of the Business Men's Association and the first president of the State Pharmaceutical Association. He had been associated with several mercantile firms in Lansing, but had been retired from the labors connected with them for many years. He was serving his third six-year term as a mem-

ber of the Michigan State Board of Health.

It is a lamentable fact that Mr. Wells should die with a preventable disease; one which he himself has made many efforts to eradicate in this State. He had given long years of faithful service to public office, and his achievements are a good illustration of the power for good which any business man may have, who will give his attention to public matters.

A Correction.

Several misleading statements have recently appeared in both medical and lay publications in regard to an address delivered in Chicago during the fall by Prof. Theodore Escherich, of Vienna. This address concerned the results obtained in St. Anna's Kinderspital in Vienna from the use of Moser's serum in scarlet fever. From the tone of comments upon the address, the idea has evidently gone forth that Moser's serum is a specific for scarlet fever as antitoxin is for diphtheria and that the results in Vienna are something unusual and particularly hopeful.

As a matter of fact, Moser's serum is not a specific for scarlet fever unless one is prepared to admit that scarlet fever is caused by a streptococcus. Moser's serum is a polyvalent antistreptococcic serum. Dr. Moser obtained his original organisms by making cultures from the heart's blood of fatal cases of scarlatina as soon after death as possible. With these a serum was obtained from horses. The method of using this serum in the Escherich clinic has been such as to preclude the possibility of proving it a specific in scarlet fever, for the reason that it has been used only in *selected* cases.

Those cases which show on admission the symptoms of the most severe type of the disease, very high fever, intense intoxication and failing strength, are the only ones to whom the serum is given. Ordinary uncomplicated cases of moderate severity receive no serum treatment. No attempt has been made to give the serum to a series of cases as they come, and to compare such a result with a similar series under other treatment. It is well known that in septic scarlet fever, the predominant organism is usually the streptococcus, so these are precisely the cases to show results when treated with an anti-streptococcic serum.

And they do show results. No one who has followed Dr. Moser's bad cases from day to day can deny that his serum has therapeutic value. But that it is a specific for scarlet fever, Escherich himself does not believe. It has no more claim to be such than American anti-streptococcic sera; and, in fact, is less useful because it is not concentrated and is not produced in marketable form.

So, much as we would like to chronicle the advent of a serum which could do for scarlet fever mortality what antitoxin has done for that of diphtheria, we can not say it of the Moser serum. That it is useful in many septic cases, however, is true, and Dr. Moser is deserving of the high regard of the medical profession because of the patient and excellent work he has done.

Prevention of Diphtheria.

In another column appears an abstract of a French article on "The Prophylaxis of Diphtheria in Schools,' to which we would like to call attention. It advocates the use of antitoxin in immunizing doses for all pupils in a school who have been exposed to diphtheria infection. It has been well demonstrated that immunity to this disease can be produced by antitoxin. How can we escape the conclusion that if a child by virtue of his compulsory attendance at a public school be exposed to diphtheria, he should also be given, at the public expense, a dose of the one medicine which it is known will protect him from having the disease?

If this plan were followed, there would be no loss of time from supension of the school. Antitoxin is expensive, to be sure, but is it more expensive for a community than a diphtheria epidemic? The subject is commended to health officers and school boards for their consideration.

EDITORIAL NOTES

Dr. H. H. Sanderson, of Windsor, Ont., was married on Jan. 11th to Miss Michleborough, a young society lady of St. Thomas.

"Tuberculosis in parents is the most frequent cause of feeble-minded and imbecile children." Downing: *Boston Med. and Surg. Journal.*

The first prize given for hospital plans exhibited at the St. Louis World's Fair was awarded to Dr. A. J. Ochsner, of Chicago, and an architect of the same city.

Dr. Roosevelt H. Davis, a graduate of the Medical Department of the University of Michigan in 1852, died at his home in Eaton Rapids, Mich., on January 7th.

Menominee has now been suffering for three months from a typhoid epidemic, but, in spite of this, recently voted down a proposition to put a filter into their water supply.

Dr. W. W. Connor, formerly city physician and health officer of Lansing, died Jan. 27th, of paresis, aged 57. He was a well known Mason and leaves a widow, son and daughter.

The Wayne County Medical Society has elected the following delegates to the Michigan State Medical Society convention, to be held at Petoskey in July: Drs. Edwin S. Sherrill, William F. Metcalf, Willis Anderson, Albert E. Carrier, Frederick W. Robbins, Guy L. Kiefer and C. W. Hitchcock.

A typhoid epidemic of great extent prevails in Manitoba; 1,166 cases have been treated in the city hospitals of Winnipeg, 289 of which came from out of town. So general has the alarm become that Prof. Oakes Jordan, of Chicago University, has been appointed special sanitary expert to investigate the situation and advise the authorities as to the best means of preventing the further spread of the epidemic.

From all parts of the State of Michigan comes news of difficulties attending the settlement of the bills of physicians who have attended small-pox cases during the recent disgraceful prevalence of that disease. If nothing else good results from the epidemic, we hope it will bring about some equable methods of paying the physicians of isolated districts for their services in the matter of public health. If a case of scarlet fever slips past a doctor unnoticed and the neighbors' children are exposed, there is an uproar; but let a poor country doctor risk his health, his practice, his family, his life perhaps, to care for an unfortunate with a loathsome disease, and to protect the community, and what does he get? Not enough, you may be sure, and just now he is having a good deal of difficulty to collect that. The State Association of County Supervisors will wrestle with the question at its next meeting.

Wanted—Position.

Lady pharmacist of 3 years' experience would like position as dispensing pharmacist in a doctor's office or hospital. References. Address—E. C., care Detroit Medical Journal.

Dr. D. G. Costello has moved from Albion to Pontiac.

Schools are closed in East Tawas, Mich., because of an epidemic of scarlet fever.

The City Physician at Saginaw, Michigan, claims the exclusive right to attend patients in the small-pox detention hospital. Other physicians dispute this right and a merry war is on.

Physicians are Much in Evidence in France politically just now. One-third of the members of the Chamber of Deputies and one-half of the Senate belong to the medical profession.

Surgeons in Paris are now dressing wounds with silver leaf. The leaf is placed over the wound or ulcer. It sticks closely, and only a little collotion is requisite to hold it in place. The effects are said to be good.

Dr. L. M. Jones, a pioneer physician of Brooklyn, Michigan, died of old age on Jan. 30th. Dr. Jones had practiced in Brooklyn since 1856, and had long been a prominent citizen in that village. He leaves one son, Dr. O. Q. Jones, of Tecumseh.

The City Hospital and free dispensary drug service of Charleston, S. C., is to be managed by the South Carolina Medical Society for ten years at an annual cost to the city of $28,000. The city has deeded the hospital building to the Society, which will spend $100,000 in improvements.

The governors of the New York Skin and Cancer Hospital announce that Dr. L. Duncan Bulkley will give a special course of four lectures on The Relation of Diseases of the Skin to Internal Disorders, in the Out-Patient Hall of the Hospital on Wednesday afternoons at 4:15 o'clock, commencing March 1st, 1905. The course will be free to the medical profession.

A freak was recently exhibited before the Berlin Medical Society by Dr. von Bergmann. This man possessed remarkable control over his muscles, moving single ones in unusual parts of his body. In addition he stops his pulse, moves his heart from side to side, causes the muscles to run in ripples over his body, and shakes isolated muscles like jelly! !

Dr. Samuel Hemingway, one of the earliest ambulance surgeons in this country, died in New York on December 18 last. He was attached to the old Park Hospital thirty years ago and was a pioneer of the service. In his practice he devoted himself to semi-surgical cases, and was one of the first physicians to advocate and practice the use of the plaster of Paris jacket in the correction of curvature of the spine. He was more than ordinarily successful in a financial way.

Dr. A. B. Prescott, director of Chemical Laboratories, Professor of Organic Chemistry and dean of School of Pharmacy of the University of Michigan, has been for some time critically ill of pneumonia at his home in Ann Arbor. Dr. Prescott is the oldest professor in years and point of service in the University, and few teachers have been more beloved by the students than he. They will all be glad to know that Dr. Prescott is recovering.

The present session of the Wisconsin legislature is to be petitioned to establish a medical school in connection with the State University.

Indiana is agitating the question of a state institution for the care of epileptics, a bill creating such an institution having been introduced into the legislature.

Got Her Name Wrong.—"The trouble with you," the doctor said after examining the young man, "seems to be that something is the matter with your heart."

"With my heart?"

"Yes. To give it a name, it is angina pectoris."

"Guess again, doc," said the young man. "That isn't her name at all."—*Ex.*

A curious libel suit has been brought against the New Orleans *Picayune* by Dr. E. Deneger Marten. Suit is brought because the newspaper published an account of an operation which the doctor had performed on a child. The operation was highly successful and the article published was commendatory in a high degree; but the physician claimed damages on the ground that his professional reputation and standing had been injured, because the society of physicians to which he belonged was averse to such publication.

To Remove Ink Stains.—Removing ink stains is a simple task. The material should first be soaked in clean, warm water, the superfluous moisture removed, and the fabric spread over a clean cloth, says the *Monthly Magazine.* Now allow a few minims of stronger water of ammonia, specific gravity 0.891, to drop on the ink spot, then saturate a tiny tuft of absorbent cotton-wool with dilute phosphoric acid, B. P., and apply repeatedly and with firm pressure over the stain; repeat the pressure two or three times, and finally rinse well in warm water, afterwards drying in the sun, when every trace of ink will have vanished. By other methods some considerable difficulty is often experienced even in removing part of the stain when it is not of recent origin; but the above method is equally reliable both for old and fresh ink stains, is rapid in action, perfect in results, and, moreover, will not injure the most delicate fabric.—*Bulletin of Pharmacy.*

A City of Cretins.—According to M. Guillaume Capus, author of "Les Medecins, et la Medecine en Asie Centrale," the author of a book entitled "Les Medecins et la Medecine en Asie Centrale," the population of the town of Khokand in Turkestan consists, for the most part, of sufferers from goitre and cretinism. The traveler entering the town is at once struck by the fact that nearly every person he meets is the bearer of a more or less voluminous goiter. Khokand is the only place in Turkestan in which such a state of things exists, and there appears to be nothing in the place or its surroundings to account for the prevalence of goitre and cretinism. Its sanitary condition is satisfactory. The town is situated at a height of 1,300 feet, and is abundantly supplied with water from a river which, like the others in the same region, comes from the Altai mountains. When the Russian troops occupied Khokand in 1878, the medical officers noticed that a tenth of the garrison became affected with goitre after a few months' stay. The tumors yielded to the iodine treatment; nevertheless, it was decided to abandon Khokand and transfer the headquarters to Marghillan.—*Medical News,* Jan. 21, 1905.

One judge in Wisconsin evidently does not think much of the judgment of their State Board of Medical Examiners. That body decided that the Harvey Medical College of Chicago, was not a "reputable" school in their understanding of the word, and they refused to allow Dr. Arthur Budan to take their examination because he was a graduate of that school. Suit was brought and a decision recently made by Judge Williams declared the position of the Board "unreasonable," and ordered them to grant the young man an examination.

Dr. Churchill Carmalt,, one of the most promising of younger New York physicians, died in that city on Jan. 9th, at the early age of 39. The cause of death was pneumonia. He was a graduate of Harvard and of the New York P. and S. He was the first house-surgeon of the Hudson Street Hospital. At the time of his death he was demonstrator of anatomy at the P. and S., a member of the house-staff of the New York Hospital, attend-surgeon at the New York Lying-In Hospital, and assistant attending surgeon at the Women's Hospital. He leaves a widow and one child.

Dr. George A. Charlton left Detroit last month to accept a most responsible post for the Canadian government in Northwest Territory. He is delegated to pursue original investigations as to the cause of Rocky Mountain Fever, and several other diseases endemic in that region. Before coming to Detroit, Dr. Charlton was successively assistant to Professor Adami, of McGill University, Montreal; and Fellow of the Rockfeller Institute with residence abroad, so he is well qualified for the work he has undertaken. While in Detroit he was engaged in standardizing the Stearns' antistreptococcic serum.

Dr. W. H. Sawyer, of Hillsdale, Mich., has announced himself as a candidate for the nomination for Regent of the State University, at the coming spring election. Dr. Sawyer is now a trustee of Hillsdale College, and a member of the State Board of Medical Examiners. He is a popular and able physician of Hillsdale, and will undoubtedly make a strong run for the place. It is certainly desirable that the Board of Regents, controlling as they do the progress of one of the most prominent medical schools in this country, should have in its membership a member of the medical profession.

Michigan has lost one of her most distinguished medical men. Dr. Arthur B. Cushny, for the last twelve years professor of materia medica and therapeutics in the University of Michigan, and author of the best English text-book on his subject, has resigned. He has accepted an invitation to fill a similar position in the medical school of London University, England. Dr. Cushny is a native of Scotland, obtained his M. D. at Aberdeen in 1886, but has done the most of his teaching in Ann Arbor. The publication of his book brought him immediately into the general notice of the profession as an authority, and he has been so recognized for several years. His admirable scientific poise of mind in teaching a subject which has scarcely emerged from the mists of quackery and empiricism, and his dry Scotch humor, have made Professor Cushny a favorite with medical students at Ann Arbor, and his loss must be greatly felt there.

Dr. Cushny leaves for London about March first. His work for the remainder of the year will be provided for by the raising of Dr. Chas. W. Edmunds, now Instructor in Pharmacology, to the rank of Acting Assistant Professor.

A consolidation has been effected between the Mecosta and Newaygo County Medical Societies. The new officers are, Dr. B. F. Brown, of Morley, president; Dr. W. A. Whitney, Big Rapids, and Dr. J. W. McNaff, of Fremont, vice-presidents; Dr. A. A. Spoor, Big Rapids, secretary-treasurer.

The Kalamazoo Asylum for the Insane is now quarantined for small-pox. The disease was brought there by a woman patient from Jackson, Michigan, broke out in a female ward and soon appeared in others so that the whole institution has been exposed. No deaths have yet been reported.

NEW INSTRUMENTS AND DEVICES.

Mention of new instruments and devices in this department is entirely complimentary and articles illustrated are judged on their merits.

We invite manufacturers and physicians to send us matter suitable for publication under this head. A description of the device and an electrotype or half-tone with a base not greater than two and five-eights inches should be sent.

Always mention the price of the article in question.

The management cannot undertake to return cuts unless postage for same accompanies the letter with which they are sent.

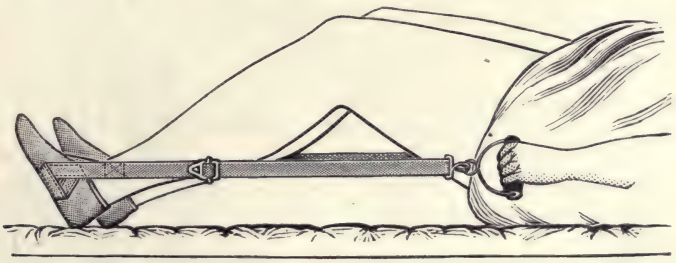
To Our Readers—The Detroit Medical Journal publishes descriptions of such aids to the profession as it knows to be reliable and trustworthy. We shall be pleased to furnish information as to the articles mentioned, or the articles themselves, upon receipt of an inquiry.

Haslam's Obstetrical Slipper.

The advantage of this simple and effective device, in labor, is readily acknowledged. It is a most desirable substitute for the similar and more expensive apparatuses.

With these slippers adjusted to suit the case by our sliding buckle, the patient is enabled to make proper traction. The patient will also remain in position and not be drawn down as is the case with tractors attached to the bed.

These slippers are strong and light, a pair weighing about seven ounces. They can be easily carried in the pocket or corner of obstetric bag. No physician or nurse can afford to be without this simple device, and on account of its low price, they may be recommended by physicians to their patients even if in modern circumstances. Price, $2.00 per pair.



HASLAM'S OBSTETRICAL SLIPPER

Aseptic Receptacle for Soiled Gauze and Cotton.

Cotton pledgets are instantly removed from probes, cotton carriers or dressing forceps, and left within the receptacle without soiling the fingers, by drawing the instruments through slots radiating from an opening in the side, one hand only being necessary to accomplish this result.

It is attached by a single screw to the upper, under, or either side of a table or operating chair, and is adjustable to any desired position by means of a ball and socket joint.

It is so constructed as to retain antiseptic fluids, and in nasal or other operations attended with hemorrhage, or in purulent discharges from the eye or ear, it is invaluable, alike to the operator and patient, by the immediate disposal and disinfection of offensive materials.

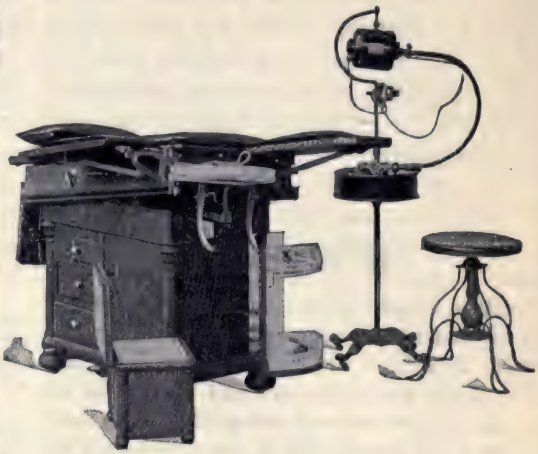
It can be instantly removed for cleansing and sterilization.

It is four inches in diameter, and made of heavy metal, nickel plated, is an ornament to the office, and will last a life time. Devised by Dr. E. W. Beebe. Price $4.00, free by express.

New Leg-Rest.

There are all sorts of new conveniences in the table shown in the cut, as a result of the combination of automatic action and the detachable leg-rest, and one of the most important is the special Sims' position here illustrated.

As only one-half the leg-rest is needed as a support for the patient's limbs, the other half may be swung to the side of table-top, affording extra space for the hips or it may be stopped at any angle from the top and used to hold a roll of cotton, bandages or instruments. The new leg-rest attachment also provides extra sockets so that the glass or porcelained steel trays may be taken from the swinging cabinets and placed on a level with the top. This saves the operator the necessity of stooping to secure the instruments needed.

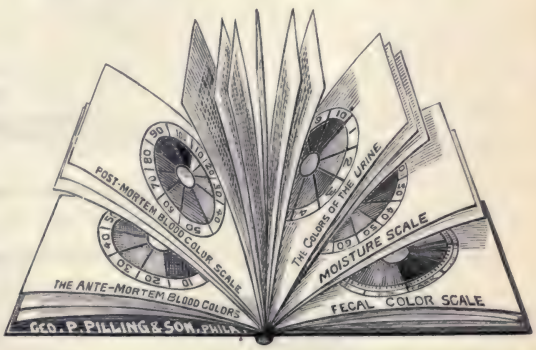


If desired, the leg-rest (which is here shown at the side of table-top) may be detached altogether and sockets left for the accommodation of the tray racks.

As the requirements of the medical practitioner become daily more exacting, any improvement which makes for the rapid and easy handling of cases is very welcome.

Haemoglobin Scale and Color Test Book.

This book for the better determination of Haemoglobin, Moisture, Perspiration; Urine and the color of the Feces, enables the student and busy practitioner to determine with practical accuracy the things tested for at the bedside.


POST-MORTEM BLOOD COLOR SCALE
THE ANTE-MORTEM BLOOD COLORS
THE COLORS OF THE URINE
MOISTURE SCALE
FECAL COLOR SCALE
GEO. P. PILLING & SON, PHILA.

The results have been compared by several competent observers, with the more expensive apparati that are not so practical, and the results have been accurate.

The Antemortem blood colors are of

particular value clinically and the arrangement of the colors in a circular manner around a perforated center is said by numerous authorities to be of advantage. In addition, the colors have been corrected over existing scales in order that the result may represent the true percentage of standard human Haemoglobin.

The Postmortem blood colors are of advantage in giving a better description of the blood at necropsy, and will give a good test of the Haemoglobin, using dried blood. (*Vide Cattell's Postmortem Pathology, 2nd edition.*)

The Moisture scale is of practical use in two ways:

First:—It will give very satisfactorily the relative humidity of the sick room.

Second:—The test papers enable us to get an exact expression of the amount of moisture thrown off as perspiration or sweat.

This is a clinical symptom to which but little attention has been paid, yet the best authorities write of its importance.

This arrangement of Urine colors facilitates a comparison not heretofore at hand.

The Fecal color scale has been made to cover a need often expressed, for at times it is of the utmost importance to have record of this matter, and with this scale we can numerically express the condition.

Designed by Dr. Henry Emerson Wetherill. Price, $1.50.

PROGRESS OF MEDICAL SCIENCE

Renal Hematuria.

Dr. B. R. Schenck (*Medical News*, December 4th, 1904), reports an interesting case of renal hematuria of unexplained origin. The patient was a woman of forty-six. She complained of passing large quantities of bloody urine and of a persistent backache. This had continued for five months. The previous history gave absolutely no etiologic foundation. Cultures were made from the bloody urine and it was found to be sterile. Cystoscopic examination showed the bladder walls normal. Catheters passed into the ureters proved that the blood came from the left one. Numerous examinations for tubercle bacilli were made, but none found. The tuberculin reaction was also negative.

After four weeks an exploratory nephrotomy was done. The kidney was found to be perfectly normal in gross appearance and a piece of the cortex examined microscopically showed no pathologic changes. The patient had an uneventful convalescence. Blood continued in decreasing quantities for three weeks and then disappeared. The patient's general condition since the operation has been excellent. The hematuria in this case remains a complete mystery. A discussion of nineteen similar cases follows with biliographical notes.

"Eye Strain as a Cause of Migraine."

Shoemaker, W. A., St. Louis, Mo. (*The American Journal of Ophthalmology, July*, 1904), in an interesting article, calls the attention of the profession to this subject.

He first gives a clear definition of migraine, touches on its recognition by the ancients and refers to the obscurity which surrounds its pathology and the many causes which have been assigned to it. Heredity is in many cases a well marked feature of the disease along the female line.

The fact that the more modern textbooks, both on general medicine and on ophthalmology, touch only lightly upon eye-strain as a patent cause of the difficulty is referred to, and Shoemaker goes on to quote various authors who do devote a little space in their works to this phase of the subject.

The author that states his conviction, which he has arrived at after a long period of observation, that eye-strain, from errors of refraction or anomalies of muscular balance, is one of the most frequent causes of this distressing affection, and furthermore states that their correction by glasses or tenotomy will frequently bring relief and cure.

In support of his position, the author quotes four illustrative cases from his case books, which briefly are as follows:

Case 1, aged 35—Migraine began at age 10 years. In this case heredity was well marked, both the father and mother of the patient being sufferers from the same affection.

He began wearing glasses at 20 years of age, and since that time the migraine has been decidedly less, but not entirely removed.

Case 2, aged 57—Had a history of migraine from age of 10 to 48 years, at which age patient began wearing glasses for reading. Since glasses were worn migraine has vanished.

Case 3, aged 32—Daughter of case 2. Migraine began at age 17, at age 19 glasses were prescribed, since which time migraine has entirely disappeared and does not recur unless glasses are discarded.

Case 4, aged 22—Daughter of case 2. Migraine began at age 8 years. Inasmuch as the eye never ached, an error of refraction as a cause of the difficulty was never suspected until the author was consulted, when a properly adjusted glass entirely relieved the difficulty for 18 months, when it recurred. A re-examination of the refraction showed a change had taken place and relief was again obtained by a readustment of the glass. In 5 years this was repeated 3 times, each readjustment being followed by a complete relief.

The author concludes as follows: "We thus have one case in which the careful correction of the ametropia gave decided relief, but did not cure. One case in which presbyopia, with the correction of the ametropia gave complete relief. One case in which inability to use the eyes on account of the pain in them, as well as the fact that they brought on migraine, was relieved by correcting the ametropia, and one case in which the eyes never ached, where the migraine was completely relieved by correcting the ametropia, but where it promptly returned on the slightest change of the refraction."—*Don M. Campbell.*

Humped Foot and Its Relation to Boots.

E. H. Bradford, Boston. *Boston Med. and Surg. Journ.,* Nov. 24, '04.

The American foot is as a rule, shoe-deformed. These deformities are produced usually without much discomfort, and their presence is unnoted on account of the small demand made upon the feet in ordinary daily life. They do manifest themselves, however, in the frequent foot-crippling of old age—and this at a time when the daily walk is especially needful for comfort—and whenever there is an increased demand for activity on the feet, as illustrated by the marching of militia which now--a-days is rarely equal to ten miles, although, during the alarm of the attack by the French fleet in the French and English War, the untrained militia of Massachusetts marched from the centre of the state to Boston, fully equipped , at the rate of thirty miles a day.

The most common shoe-deformities are caused by crowding the toes together, as the shoe is always made narrower than the natural spread of the foot. This crowding results most injuriously upon the great toe which is pushed towards the middle of the foot and is frequently partially dislocated. This effect is increased by the customary stiffened toe-cap which prevents stretching of the leather. With the weakening from non-use of the muscles governing the toes, the weight-bearing function of the foot is impaired, and an abnormal strain comes upon the middle portion of the foot, which is increased by the toeing-out position assumed in order to supply the breadth of base which has been lost through the narrowing of the front of the shoe. This strain tends to produce the pronated position of foot-weakness and leads to flat-foot. A recent deformity

of the foot, due to the recently fashionable last that is flat and low over the heads of the metatarsals, is a metatarso-tarsal valgus, or "humped-foot." This is characterized by an angle on the dorsum of the foot, pointing upwards and inwards, at the inner metatarso-cuneiform articulation, perhaps with irritation and exostosis.

The remedy for these deformities, in the way of better-shaped shoes, is easy to prescribe but difficult to apply. The remedy must come by educating the public demand regarding shoes as has been done, with resultant improvement, regarding corsets and, to some extent, regarding also men's shoes. Children should wear moccasins, sandals, and loose, light shoes. The working shoes of women should be like those of men, and all persons should have working as well as dress shoes, and, when at leisure, should wear moccasins or Turkish slippers.—*Wm. E. Blodgett.*

BOOK REVIEWS

Manual of Materia Medica and Pharmacy, by E. Stanton Muir, Ph. G., V. M. D., Instructor in Comparative Materia Medica and Pharmacy in the University of Pennsylvania. Third Edition, revised and enlarged. Philadelphia: F. A. Davis Company, 1904. $2.00.

This manual is an excellent accompaniment to some such standard text on pharmacology as Cushny. The contents are divided into three parts. One part deals with the sources of drugs, especially those derived from the vegetable kingdom; the larger part consists of an alphabetical list of the more commonly used drugs—their physical character, general action, dose, etc. Each alternate leaf is blank for note taking. The third section is a brief treatise on pharmacy and contains a judicious selection of useful formulae from the Pharmacopoeia.

The attempt to teach therapeutics from such a manual as this alone is to be strictly deprecated; but, as stated above, the volume is a very convenient one for rapid reference.

Handbook of the Anatomy and Diseases of the Eye and Ear for Students and Practitioners, by D. B. St. John Roosa, M. D., LL. D., Professor of Diseases of the Eye and Ear in the New York Post-Graduate Medical School; and A. Edward Davis, A. M., M. D., Professor of Diseases of the Eye in the New York Post-Graduate Medical School. Philadelphia: F. A. Davis Company, 1904. $1.00.

This volume of pocket size gives every indication of filling a useful field. Prepared ostensibly for the clinic-hunting student or post-graduate, it affords him an anatomical guide, an account of various instruments, diagnostic and otherwise; and a brief treatise on the diseases of the eye and ear with diagnostic and therapeutic points. The names of the authors guarantee that the statements are sound. The ground covered is well adapted to the purpose of the book.

An Introduction to Dermatology. By Norman Walker, M. D., F. R. C. P., Edinburg. Third Edition, revised and enlarged. With 49 full page plates and 50 illustrations. Bristol, England: John Wright & Co., 1904. $2.50.

This volume is the most satisfactory as a short text-book on diseases of the skin with which the reviewer has met. Aiming to cover only the more common skin affections, it still offers such an excellent short account of modern pathology of the skin, and such full notes on treatment that it cannot fail to be a val-

uable book for the library of any physician in general practice. The illustrations are mostly very successful and are unusually numerous and good for a short treatise.

It might be said that in his effort to include titles and still preserve the convenient size of his volume, the author has condensed his remarks on some subjects to such an extent that they might better be omitted. For example, no one unacquainted with the condition would ever recognize *sclerema neonatorum* from the description given by the author. Others might be mentioned.

But, on the whole, the book fills very well the field which it seeks to cover.

A Practical Treatise on Nervous Exhaustion (Neurasthenia) Its Symptoms. Nature, Sequences, Treatment. By Geo. M. Beard, A. M., M. D. Edited, with notes and additions, by A. D. Rockwell, A. M., M. D. *Fifth Edition—Enlarged.* New York: E. B. Treat & Co., 1905. $2.00.

It can hardly be doubted that this volume has filled a useful place in the library of many physicins, since five editions have been called for. To the present edition has been added a chapter on The Neuron Theory in its Relation to the Treatment of Neurasthenia. In it the author vigorously champions the plan of treating functional neuroses by physical means.

The book is eminently a practical one and can hardly fail to be full of suggestion to one treating cases of this perplexing and tedious disease.

International Clinics: A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles Edited by A. J. O. Kelly, A. M., M. D., John H. Musser, M. D., J. B. Murphy, M. D., Thos. M. Rotch, M. D., and others. Vol. IV. Fourteenth Series, 1905. Philadelphia and London: J. B. Lippincott & Co. $2.00.

Among the many valuable articles presented in this volume to the readers of this excellent quarterly digest, we may mention the following as of peculiar interest and value of the general practitioner: (1.) Recent Investigations Concerning the Pathology of the Infectious Diseases, by Prof. Aldred Scott Warthin, of Ann Arbor; (2.) Nerve Anastomosis for the Cure of Infantile Palsy, by Jas. K. Young, of Philadelphia; (3) Lateral Curvature of Spine, by Prof. E. H. Bradford, of Harvard Medical School, and (4.) Functional Heart Murmurs: Their Causation and Diagnosis, by R. D. Rudolf, of Edinburg. The first especially, is a very valuable appreciative and critical article. The titles show how well these articles are selected from the viewpoint of the practical.

Many other valuable articles are included among which Prof. Senator's lecture on The Clinical Significnce of Albumosuria is notable. Important scientific contributions are The Etiology and Pathology of Amoebic Infection of the Intestine and Liver, by Chas. F. Craig; and Chronic Polycythemia, by F. Parkes Weber and J. H. Watson. We can only say that it is still a problem to us how such a high standard of professional worth is maintained and the volumes published at the low price asked. The illustrations are many and excellent. We can hardly imagine a purchaser of this volume disappointed.

RECEIVED:

(Grateful acknowledgment of the receipt of the following is hereby made. Further notice in our review column may be given).

Fourth Annual Report of the New York State Hospital for the Care of Crippled and Deformed Children. Newton M. Schaffer, Surgeon-in-Chief. Tarrytown, N. Y.

A Contribution to the Study of the Prognosis of Syphilis. By Noah E. Aronstam, M. D., Detroit. Reprint, 1904.

Text-Book of Alkaloidal Therapeutics, by W. F. Waugh, M. D., and W. C. Abbott, M. D. Clinic Publishing Co., Chicago, 1904.

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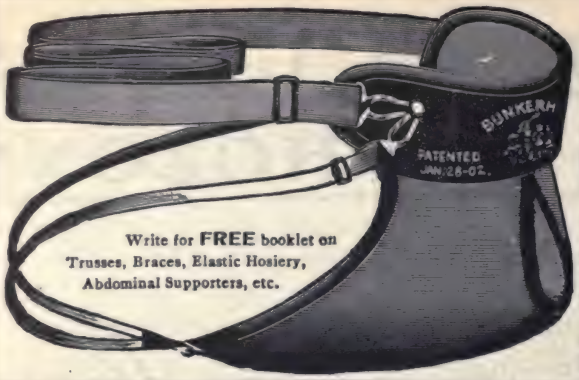

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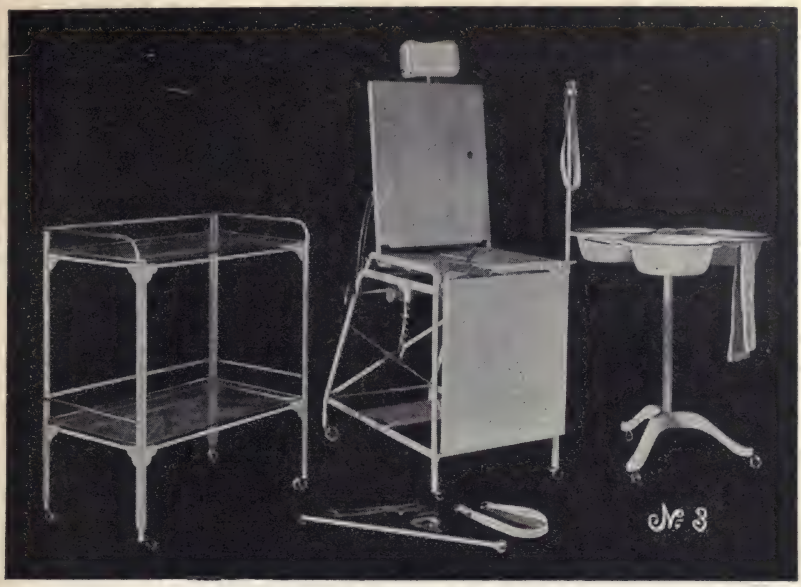

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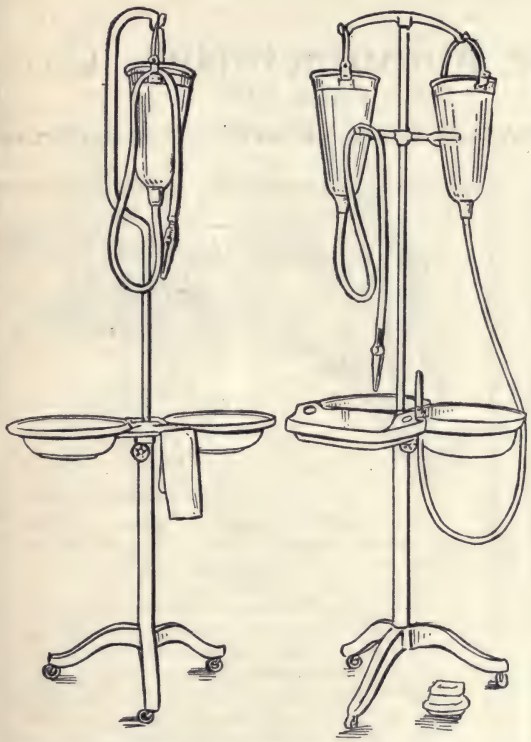

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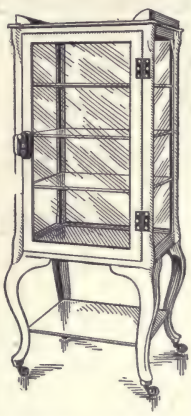

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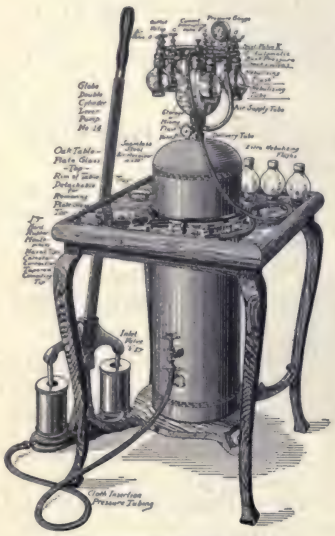

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A New Remedy and Results.

By JOHN H. SLEVIN, A. M., M. D.
25 Rowland Street, Detroit.

Let it be understood that in presenting this paper for the consideration of the readers of this journal, I do not desire to seem to be in the position of assuming to force my opinion as to the value of the remedy concerning which I write upon that portion of the medical profession who may take the time to read this article, but rather to be a recorder of results obtained from its administration in my hands as well as in those of Dr. George H. Shelton, with whom I have the honor to be associated. The paper, then, is of an absoluetly clinical status, and I ask the reader to kindly consider it in that light.

The remedy with which this aper has to do is known by the trade name of Fermisal, the name being taken from the ingredients of which it is composed, namely: Iron, mica, silica, and aluminam; the formula, therefore, is no secret. Further description of the remedy itself I will leave to the report of the analysis made by Dr. Frank T. F. Stephenson, of this city, which here follows:

Detroit, Mich., Aug. 25th, 1904.

Chemical Report.

Sample of red powder received on August 6th. Required information as follows: Fineness, absorbing power, relative volume, germicidal or antiseptic power, standing effect, chemical constitution and formula for a glycerine paste similar to Antiphlogistine, using the powder instead of clay as a base.

Fineness—80-90.

Absorbing power—1¾ times that of clay used for Antiphlogistine, glycerine being used.

Relative volume—greater than the clay, in ratio of 1 to 15-23.

Bacteriologic effect—Inert, both as germicide and antiseptic, by incubator tests. Sample not sterile.

Staining effect—positive. Cloth placed in contact with wet powder for 48 hours iron stain.

Five grams of sample, when dried at 100 degrees for 24 hours, showed loss from moisture——3 per cent.

Five grams of sample when heated to red heat for 12 hours, showed loss of organic and violatile matter——9.9 per cent.

This residue showed the following constitution:

Silica	46.509
Alumina	11.939
Ferric oxide	41.230
Magnesia	traces
Potassium	traces
Undetermined	.322
	100.00

Remarks:—This sample is a mica, which has undergone almost complete "weathering." The original structure is gone, and the magnesium and potassium normally present have been almost entirely washed out. It is hard to judge accurately from a powdered sample alone, but the analysis leads to the conclusion that the sample was originally a mica of the biotite division, and probably the variety known as lepidomelene.

When sterilized, this powder will be valuable as a base for a glycerine paste, and better than the clay now used. The powder will carry at least 50 per cent more glycerine than the clays now used.

As the result of its absorbing properties, it will be useful in treating wounds, etc., where large quantities of fluid are present. It should be sterilized, of course. As it is insoluble, it will not readily "cake" in the wound, as many powders do. It may be mixed with any of the present compounds used for dressing powders, in any proportion desired.

Case No. 1: Pnumonia in infant. Jan. 1, 1904. P. R. Male, age 5 months. Temp. 103.5; pulse 160; respirations 40. When called mother told me child had had a cold for two days which gradually grew worse until today she became alarmed and decided the Doctor had better be called. I found child coughing constantly, occasionally raising grayish, rusty colored sputa, temperature, pulse and respiration as above recorded. Chest examination disclosed rales which could be plainly heard. Prescribed as per my usual custom in such cases, and having a supply of Fermisal paste on hand, had some spread on muslin as thick as a dollar and applied to chest. Returned next day to be told baby slept all night, although the two previous nights he had been awake all the time. I found the boy perfectly happy, cough very slight; temperature normal and no necessity for any further attention from me.

Case No. II: Cancer of left breast. Jan. 15, 1904. Mrs. J. D. Age 30. For over a year have been attending her for cancer of left breast. She suffered intensely from pain. All that I could think of and several other physicians called in consultation, was done to relieve the pain. In desperation I applied Fermisal paste. In one hour pain stopped and from thenceforth patient was free from pain. Continual application of Fermisal for a period of two months not only caused cessation of pain, but produced healthy granulations and scar tissue. Unfortunately this case could not be followed to its logical conclusion on account of the intemperate habits of the patient.

Case III: Syphilis. Mixed infection. F. A. B. Age 18. male; clerk; single. This young man had ten chancres of the soft variety, as well as syphilitic infection. The hard chancre or primary lesion of syphilis was situated between the lips of the meatus. The chanchroids were upon the glans penis. These sores were extremely painful, in fact, the patient could not bear to have them dressed unless a solution of cocaine (6 per cent.) was first applied. On June 28th the usual dressing was discarded and ulcers dressed with Fermisal powder. Next day patient said, "Doctor, that red powder is the stuff. No pain since you applied it."

I was able thenceforth to dress without the use of cocaine and the continued use of Fermisal powder applied once daily cured the local trouble in three weeks. Patient still continues constitutional treatment and is doing finely.

Case IV: Phagadenic Chancroids. C. S. Age 35. Male; clerk; married. On July 10, 1904, patient came under my care atfer having been treated for two months unsuccessfully by two Detroit physicians. He had four phagadenic chancroids situated on pubes and shaft penis. That on pubes was as large as a silver dolar and had been and was spreading rapidly nd in conjunction with other sores thretening the destruction of penis. The pain from the chancroids was almost unbearable, the patient stated. I cleansed sores in usual manner; dressed with Fermisal powder and from the first dressing pain ceased; continued daily dressing with above mentioned powder and is-charged patient entirely well September 6th. Have seen him repeatedly since and there has been no return of the trouble.

Case V: Chancroids. Aug. 30, 1904. T. M. B. Age 38; merchant; male; married. Chancroids on glans penis two in number, appeared Aug. 29, two days after intercourse; dressed with Fermiasl powder in usual manner; discharged September 2, 1904, cured.

Case VI: J. B. Afe 24; female; seamstress. This case is one concerning which more might be written than I can find time to give to doing so. Let it suffice to say that she had about every symptom under the sun. In March of this year I had her at the hospital, when the os uteri was dilated, the rectum dilated, the clitoris, which had been bound down by its hood, set free. I believed this would relieve the train of symptoms, purely nervous, so far as I could fathom, from which she suffered, and my opinion was supported in this by one of our ablest and most noted surgeons with whom I was associated at the time. For months at a time she could not urinate unless per catheter; this was followed by obstinate diarrhoea, this to be succeeded by most persistent constipation, so that for a period of five months she did not average more than two stools per month, and this in spite of the fact that she ran the gaunt of every known cathartic, purgative and laxative that either I or my associates could think of, either singly or in combination; but all to no avail. On one occasion she went to the office of the surgeon already hereinbefore mentioned. He told her to take one meal a day and report in one month. She complained to his office girl that he had not prescribed for her. The girl reported the matter to the surgeon and he replied: "Doctor S. —— has done all the prescribing necessary in that case. I have troubles of my own." In a conversation with me afterwards, she said, "I would not suggest to the Lord that, if he believes I have been so bad as to deserve eternal punishment, all he has to do is to give me one thousand cases such as Miss J. B., and I will be eternally punished right here." All this preparatory to showing the stubbornness of the case. I have always felt that it

was purely a hypocondriacal case, yet she certainly has suffered acutely; but of all her symptoms, only two interest us in this paper, the chronic constipation and an acute pain situated in the region of the left ovary. When examined under chloroform, no lesion of the ovary could be discovered, yet this pain was constant and extremely acute, frequently causing her to take to bed. On September 10, 1904, I applied Fermisal paste to left side and prescribed Fermisal grs. V. after each meal to be taken internally. For four days after the Fermisal was first applied, the pain in left side was much more acute, but after the fourth daily application, and dating from the fifth application, the pain became less acute and more bearable, until at the end of three weeks the pain had ceased, and there has been no further return of it. The administration of Fermisal internally seems destined to overcome the constipation in this case, as after two weeks administration of the remedy the bowels have moved twice each week, until last week, when there were three movements.

Case VII: Abscess of Anus. Mrs. D. H., age 23, married, no children. On September 13, 1904, was called to her home to see her. Found patient confined to bed and lying on her abdomen. She said she had been unable to leave her bed for the past four days and that it was impossible to change her position unless she suffered excruciating agony, on account of a pain which she referred to the region of the anus. Examination of the anus disclosed nothing. Digital examination within the rectum was of no avail; so that I decided, and so told she and her husband, that the trouble was either purely of a nervous character or there was some deep-seated pus present. I should here state that for the four days in which she had been confined to bed antiphlogistine poultices had been kepts on the parts constantly. I ordered the following cleansing enema: Two quarts warm water to relieve lower bowel; insertion of Fermisal suppository in rectum; Fermisal paste applied to anus, externally; 9, 14, 04, condition unchanged; 9, 15, 14, patient says that paste draws terribly. Digital examination of rectum, find an abscess at top of anal ring pointing into rectum; externally hard swelling; continued treatment, 9, 15, 04; removed paste and find fluctuating abscess, on external anus, incision of same brought one pint of greenish, stinking pus, which was of such a penetrating odor as to permeate every room of the little cottage in which patient resided. The further history of the case is found in the expression: Complete and uneventful recovery, no further trouble.

Case VIII: Scald of leg. T. B., age 68; brickmason, married. September 21, 1904, leg scalded while working for Detroit City Gas Co. Dressed with Fermisal at 10 p. m., on 21st, about six hours after the accident. Called next day; patient said he was a great believer in Wonderful Dream Salve, and that he proposed using it. I said, all right, it is your leg and your privilege to do with it as you please, but remember it is contrary to my advice that you undertake to handle this case yourself. 9, 26, '04, sent for me to tell me he was suffering extremely from pain in his leg. Examined leg and it was in frightful condition, almost gangrenous. Cleansed with antiseptics, dressed with Fermisal paste. The dressing was no sooner applied when patient exclaimed, "By George, Doctor, that stuff stops the pain, anyway." Suffice it to say, Fermisal stopped the pain, reduced the inflammation, and in three weeks healed the scalded leg.

Case IX. Cancer of rectum; 9, 26, '04. Wm. K. Married, age 34, bricklayer. Cancer of rectum of few years' standing; had been operated upon three times; no relief. Promised nothing when I prescribed Fermisal suppositories (rectal), one to be inserted night and morning; Fermisal gr. X three times daily internally. October 3 patient reported that there was not as much pain since he began to use the remedy. At the time of writing this paper nothing further has been heard of the case.

Case X: Chronic gonorrhea and stricture of urethrea; 9, 28, '04; H. R., age 24, male, single, ironworker. For two years has had continuous urethreal discharge; when he urinates it is very painful, so much so that he says he hesitates when he has the call and wishes he did not have to urinate. Urethreal examination per urethroscope; urethrea so strictured that I had great difficulty to insert a 20 tube. Discovered condition stated in heading. Prescribed usual internal formula; daily urethreal irrigation; gradual dilatation; beginning with 20 F. sound, inserted nightly one Fermisal drainage bougie, 11, 15, '04; now pass a 30 F. sound with more ease than the 20 could be passed; no discharge and there has been no pain when urinating from October 4, 1904.

Case XI: Chronic gonorrhea and stricture; July 30, 1904, D. S., age 28; tinsmith; single;; chronic gonorrhea and stricture of three years' duration. Had treatment with various physicians with no relief. Usual internal medication, gradual dilatation with metallic sound, beginning with 14 F. scale and ending treatment with 26 F. scale. Inserted Fermisal Drainage bougie at night. Discharged absolutely well October 26. Saw patient November 20 and he said he was enjoying life now as he had not been able to for three years.

Case XII: Suppurative Mastites. Sept. 28, 1904. Mrs. W. H., age 23, mother of female child one year old. For two weeks her right breast had been inflamed. She complained some, but did not let anyone know how terribly she suffered. Antiphlogistine had been applied, also flaxseed poultice, but finally on September 28, the pain became so excruciating and breast so swollen and angry looking, that she and her friends became alarmed and her husband called me to see her. I prescribed a plaster such as I had been accustomed to having applied in such cases, and on my return on September 29, condition was much worse, and breast as hard as a rock. I then thought of Fermisal paste and applied a good stiff plaster of same, quite hot, remarking at the same time that it had been my experience in using this paste that when it is applied where there is pus it makes the pain more intense while drawing the same (pus) to the surface, but it will bring it to the surface speedily, soften the swollen parts and put them in condition for lancing. I further stated I would lance the breast next morning; Sept. 30, when I entered patient's room I could at a glance see that the strain of the past weeks had passed, the agonizing look had disappeared from the little woman's face. I said, "Well, are you ready for my knife?" She replied, "I don't think you need to use your knife, doctor, I am all right. I have been just waiting for you to come so that I could go to sleep. Last night and until 4 o'clock this morning I suffered the tortures of the damned, and my husband said: "Take that darned paste off and you'll get some ease.' I replied, 'I will not; the doctor told me it would make me suffer until the pus is set free and I am going to leave the paste on and do just as he tells me,' and I am glad I did, for at 4 a. m. something seemed to snap and break in my breast and from that instant I have had ease." I removed the paste to examine the breast and found the poultice saturated with pus which was draining from three small punctures close to the nipple. Continued the paste for three days, when breast was entirely healed and there has been no further trouble.

Case I: Gonorrhoea in female. July 15, 1904. Mrs. L. Aged 18; married about three months; infected by her husband; came under treatment six weeks after infection; vulva terribly swollen; had profuse, yellow, purulent, stinking discharge from uterus; also had sympathetic buboes. Suffered pain whether standing, sitting or in recumbent position. Prescribed one Fermisal vaginal suppository to be inserted at night. Hot douche night and morning. Pain and inflammation disappeared in a few days, also foul odor, and she was entirely cured in two weeks from date of beginning treatment.

Case II: Erysipelas head and face. Nov. 15, 1904. A. H., age 38; married, lumberman; temp. 103; pulse 130. Head and face so swollen as to make his features unrecognizable; intense pain at the occiput, which prevented him from sleeping and kept him in perfect agony. Applied Fermisal paste and he had relief from pain in 20 minutes therefrom. Continued application of Fermisal and discharged patient entirely well Nov. 26, 1904.

Case III: Metritis-Catarrhal. June 6, 1904; L. A. Female, age 22; single; domestic; catarrhal metritis of long standing; patient not clear as to the length of time condition has existed. Had a profuse, acrid discharge which scalded labia and perineum. Fermisal vaginal suppository at night, hot douche night and morning brought about a cure in four weeks.

Case IV: June 20, 1904. Severe burn of left arm below elbow. C. S., age 35; female, married; caused very intense pain until the application of Fermisal powder dusted on, which gave complete relief in half hour and no further trouble therefrom.

Case V: Hay fever. August 15, 1904. Miss J., aged 35. Simple, acute attack of hay fever. Fermisal powder blown into nostrils by means of a

powder blower cured case in three days. No return of trouble. This case is typical of two other cases in which relief and cure was just as speedy.

Case VI: Nasal Catarrh. July 10, 1904. Annie S.; age 14; female; nasal catarrh; three years' standing; resisted all other treatment; used powder with powder with powder blower to be blown into nostrils three times daily; cured completely in six weeks; no return of disease. Further tests of its remedial value in nasal and bronchial catarrh now in progress are satisfactory.

Case VII: Injury to fingers; May 23, 1904. J. W., age 17; printer; had three fingers of left hand crushed off by printing press; dressed with Fermisal powder, bandaged; never had any swelling, pain nor inflammation and injured stumps of fingers healed nicely.

Case VIII: Sept. 6, 1904. Ed. P., age 40; single; gentleman of leisure; fell through a window and received a semi-circular cut on the back of the left hand which measured six inches from tip to tip of the skin flap which was trown back over the hand by the cut. The wound was repaired with 10 stitches. (Silk worm gut being used). Dressed with Fermisal powder and bandaged. Patient was instructed to report in five days if no bad symptoms appear. This he did not do, did not put in appearance until the twelfth day after the wound was dressed, when it was found that the wound had entirely healed, sutures had been absorbed and there was no necessity for a second dressing.

Time forbids that I should go into detail as regards the balance of the cases treated with the remedy, and therefore, in closing this record I will merely enumerate the cases and note results in passing: Two cases of ulceration os uteri; one ulceration oss uteri and prolapsus, all very much benefited, still under treatment; one case sprain of right wrist relieved of pain almost instantly, swelling and inflammation rapidly reduced; two cases Colles' fracture, in which pain was almost unbearable were relieved of pain and swelling reduced in 24 hours, so that diagnosis was plain and remedial measures easily adopted; five cases blood poisoning, one second finger right hand, one little toe, left foot; one thumb, left hand; one thumb, right hand; one index finger, right hand, all localized and eventually cured by the application of Fermisal paste.

CONCLUSION.

From what we have seen, Fermisal seems to allay inflammation, control pain, destroy odor, and heal, doing it all speedily. Why? The chemical analysis shows it has no bacteriological nor antiseptic properties. How then, does it act? In my opinion—remember this is merely my opinion, no dogmatic utterance—it acts by feeding the tissues, thus building up the resistant powers of the part or parts of the body attacked by disease, and so the natural powers of the body to ward off disease being restored, it is capable of withstanding the attack of the invading germ, microbe or bacillus. Whether or not this opinion be correct, it does not detract from the fact, as the cases hereinbefore recorded show that in no case has Fermisal done harm; in all, it has done good; some have been cured by it alone, some have had cures hastened by its use, and all have derived benefit therefrom. Can it be possible that these results could be obtained if the remedy had no merit? I leave the answer to those who may be induced to try its merits and prove its worth by clinical trial. In the use of this remedy I have found that it works equally well as a powder or in a paste made with glycerine, vasaline or even butter. I do not find that either the paste or powder loses any of its virtue by being exposed to the air.

La Grippe and its Sequelæ again Prevalent.

The following suggestions for the treatment of La Grippe will not be amiss at this time when there seems to be a prevalance of it and its allied complaints. The patient is usually seen when the fever is present, as the chill, which occasionally ushers in the disease, has generally passed away. First of all, the bowels should be opened freely by some saline draught. For the severe headache pain and general soreness give an antikamnia tablet, with a little whiskey or wine, or if the pain is very severe, two tablets should be given. Repeat every two or three hours as required. Often a single dose is followed with almost complete relief. If, after the fever has subsided, the pain, muscular soreness and nervousness continue, the most desirable medicine to relieve these and to meet the indication for a tonic, are antikamnia and quinine tablets. One tablet three or four times a day, will usually answer every purpose until health is restored. Dr. C. A. Bryce, Editor of "The Southern Clinic," has found much benefit to result from antikamnia and salol tablets in the stages of pyrexia and muscular painfulness, and antikamnia and codeine tablets are suggested for the relief of all neuroses of the larynx, bronchial as well as the deep seated coughs, which are so often among the most prominent symptoms. In fact, for the troublesome coughs which so frequently follow or hang on after an attack of influenza, and as a winter remedy in the troublesome conditions of the respiratory tract, there is no better relief than one or two antikamnia and codeine tablets slowly dissolved upon the tongue, swallowing the saliva.

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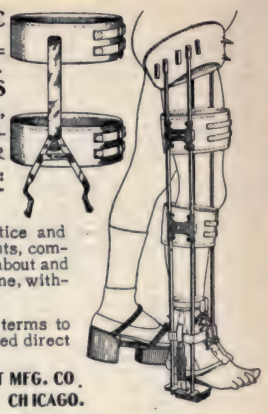

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A Substitutor Convicted.

KRESS & OWEN vs. CRUTTENDEN.—On the 8th day of December, Police Magistrate Denison, in the Police Court, registered a conviction against Thos. Cruttenden, Jr., who keeps two drug stores in Toronto, one at the corner of Howard and Sherbourne Streets, and the other at the corner of Gerrard and Sumach Streets, for infringement of the trade mark, duly registered in Canada, owned by Kress & Owen Co., 210 Fulton Street, New York, "Glyco-Thymoline." The evidence conclusively showed that the defendant had put up a preparation under the name of "Glyco-Thymol," and with labels worded verbatim et literatim to those of the original manufacturers. The magistrate in registering the conviction, gave the defendant's solicitor, who hinted at an appeal, to understand that if he entertained that idea he would not only fine but imprison his client as the law provided. The case was adjourned for a week, at the end of which time Cruttenden, through his solicitor, gave an undertaking that he would stop all manufacture of Glyco-Thymol and destroy all labels, bottles, etc., connected with the sale of that preparation. The firm of Kress & Owen Co. are deserving of congratulation over the result of this case. They had every reason for prosecuting Cruttenden, as it was nothing short of dishonest and entirely contrary to the law, that he should stoop to such practices and try to rob the firm who by strictly ethical advertising (wholly to the profession) and the expenditure of about $175,000 per annum, have secured a large sale of Glyco-Thymoline, a preparation found valuable in catarrhal conditions of the mucous membrane.—(Canadian Journal of Medicine and Surgery Editorial, January, 1905.)

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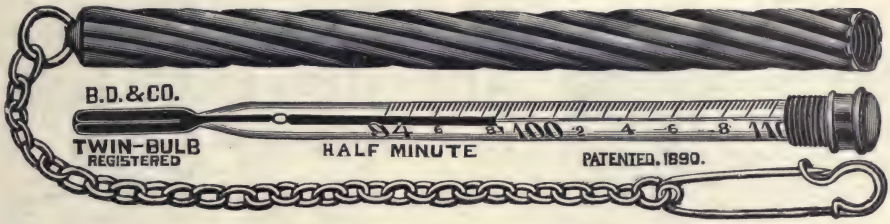

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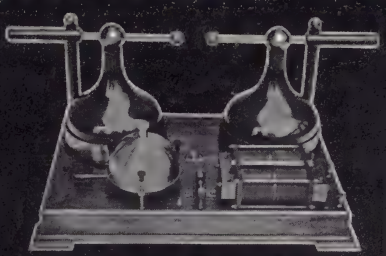

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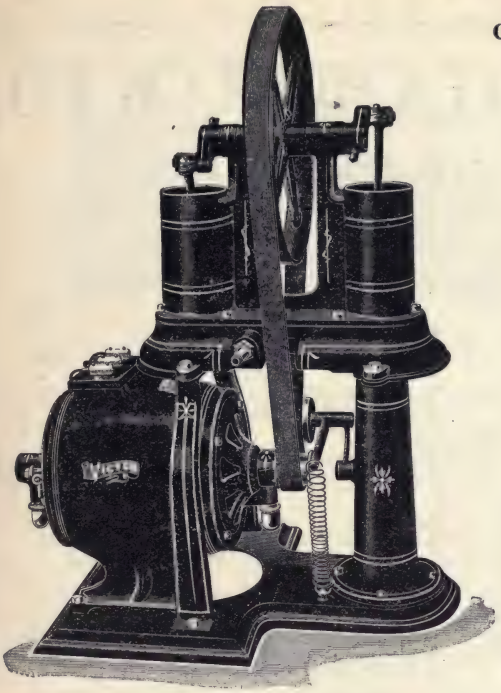

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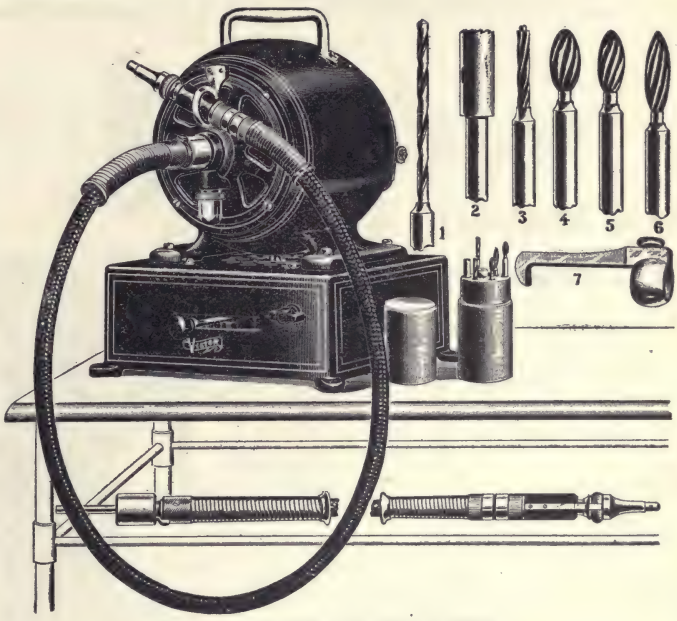

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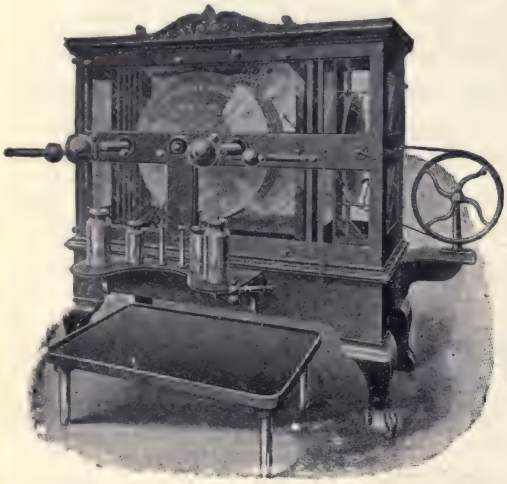

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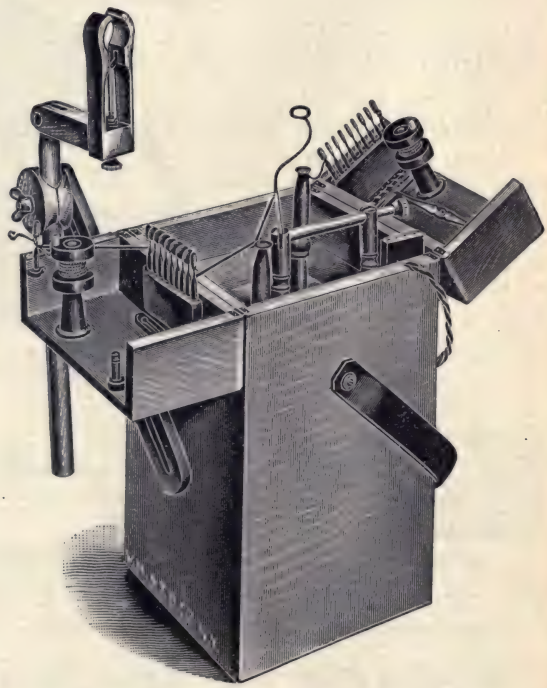

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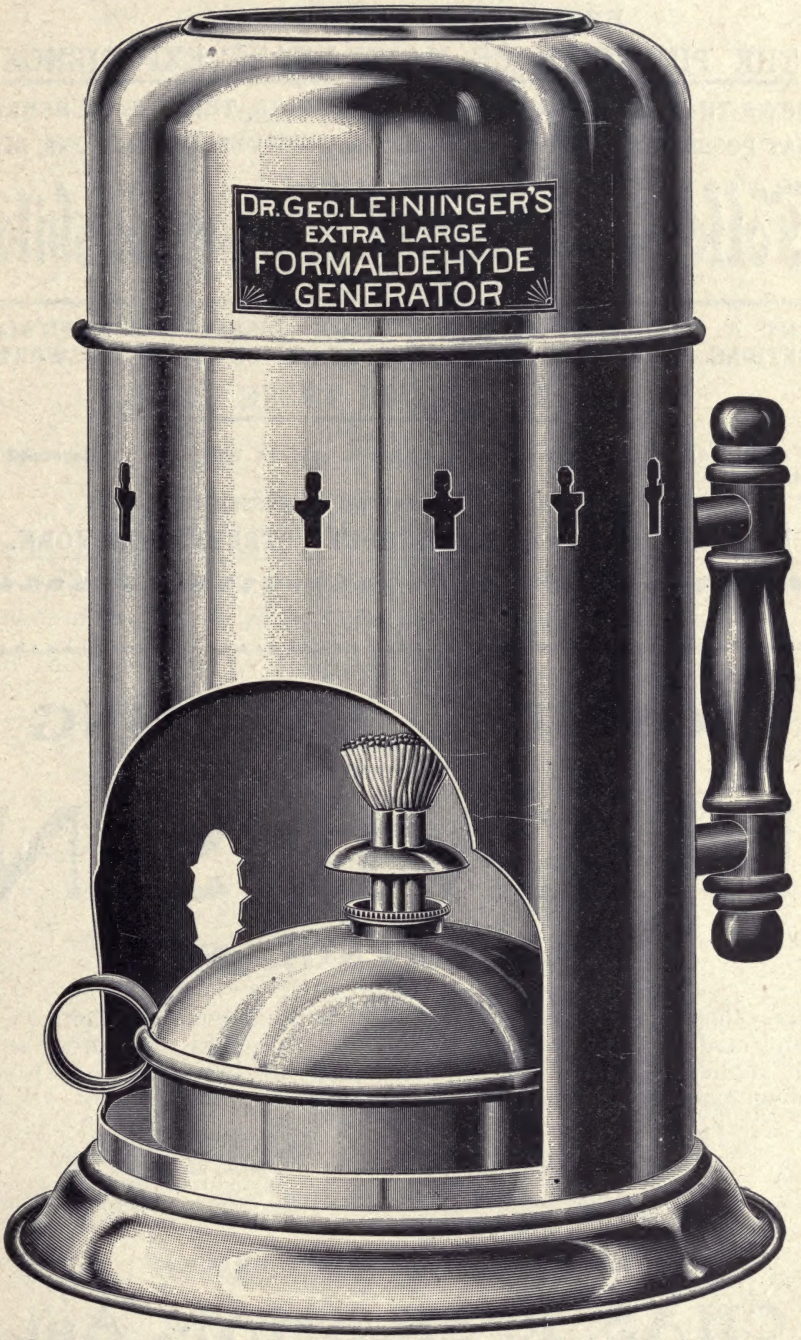

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